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ABSTRACT

This book examines the field of dance therapy from its inception in the 1940's to the present. A detailed analysis is conducted of the theory and practice of the major pioneers. The book covers biographical reports and the influence of many dance therapy leaders. Laban Movement Analysis (LMA) is discussed as well as dance therapy in specific patient/client settings. Appended are: (1) listing of survey repondents; (2) information on the American Dance Therapy Association; and (3) the Dance Therapy questionnaire. A 34-page bibliography is included. (JD)

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Dance Movement Therapy

A Healing Art

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Fran J. Levy
Ed.D., M.S.W., A.D.T.R.

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Dance/Movement Therapy

A Healing Art

Fran J. Levy
EdD, MSW, ADTR

sponsored by the
National Dance Association
an association of the
American Alliance for Health, Physical Education, Recreation, and Dance

On the cover: "Desperate Heart," photo by Barbara Morgan, dancer Valerie Bettis.

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The American Alliance for Health, Physical
Education, Recreation, and Dance
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Dedication

To my parents, Dr. Henry and Mrs. Lillian Levy, who shared with me, in countless ways, their love of life and deep appreciation for personal and artistic expression.

To my mentor, Dr. Sidney Levy, whose infinite wisdom and compassion have left an indelible mark on my career and my life.

To Dr. Levy's wife, Estelle, just for being the wonderful and generous person she is.

To Tasso, whose spirit still reverberates in the hearts and minds of many.

And finally, to a special little girl who inspires me every day, but whose name must for now remain Nameless.

About the Alliance

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Bylaws, Article III

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Preface

In recent years there has been a resurgence of interest in body movement and dance, accompanied by a growing recognition of the profound benefits of motor activity on mind and body. Simultaneously, the need for individualized styles of self-expression and communication has received greater recognition. This is evidenced in the proliferation of new forms of action oriented and creative arts therapies.

The concern of this text is with the need that many individuals have for nonverbal, primarily physical forms of expression, and how this need fueled the development of a new psychomotor discipline. The theory and practice that make up dance therapy, how they emerged, who they help and how, in addition to an examination of the entire field from its inception through the present, is the subject of the pages that follow.

Most often referred to as dance therapy or dance/movement therapy, the discipline has also adopted many branch names, such as movement psychotherapy, psychoanalytic movement therapy, Jungian dance movement therapy, psychomotor therapy, and so on. The American Dance Therapy Association (ADTA) has adopted the policy of referring to the discipline as dance/movement therapy. The alternation in the field between the designations "dance" and "movement" stem largely from concern over preconceived ideas of what "dance" means to people. Some people feel inadequate, silly, or embarassed when the word is used. Others fear they will have to perform dance steps or display an aptitude for body movement, as opposed to simply expressing their thoughts and feelings. In fact, the psychomotor expression witnessed in sessions at times does not resemble dance in any formal—or even informal—sense. For example, an arm reaching out, a fist gesturing in rage, the symbolic rocking of a child, or even the tilt of a head may all be elements of the expressive and exploratory process of dance therapy. While some will still joke about the "angry mambo," the "inspirational cha-cha," and "dancing one's troubles away," these stereotypes are quickly fading. Today, the field, broad in its application and diverse in its methodology and theoretical foundations, extends into every area of mental health.[1]

Dance therapy is a form of psychotherapy, differentiated from traditional psychotherapy in that it utilizes psychomotor expression as its major mode of intervention. The pages that follow explore the theory, practice, and origins of dance therapy. The text begins with an explanation of how, in the early part of the century, the evolution of both the modern dance movement and the field of psychotherapy and psychoanalytic thinking laid the foundation for the emergence of dance and movement as a form of psychotherapy. The brief review of these areas reveals several important overlapping trends. The early twentieth century brought an emphasis on deeper self-expression and self-exploration, a striving toward more honest communication and interaction, a growing acceptance of the inherent interaction between mind and body, and a recognition of the uniqueness of the individual and individual needs. These diverse areas of self-expression, one that originally focused primarily on the mind (psychotherapy) and the other on the body (dance), broadened their parameters in the early

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[1] For purposes of consistency and ease in reading, this text will refer to the discipline simply as dance therapy.

1900's and, in turn, merged dramatically in the 1940's and 50's, giving birth to a new discipline—dance therapy.

Unit I comprehensively discusses the major dance therapy pioneers, those who laid the groundwork for today's practice and influenced an entire generation of dance therapists. The major influences on their work and a complete review of their theoretical and practical contributions are included. Unit I culminates with an outline depicting the state of dance therapy practice as it had emerged by 1960. This outline illustrates how far the field had come in its methodology and how the original leaders laid a complete and diversified foundation for today's practice—a foundation which, when understood, serves to clarify the state of art today.

Unit II explores subsequent developments in the field. First, it reviews the profound influence on dance therapy of Laban Movement Analysis (LMA) and/or Effort/Shape, introduced into the discipline in the 1960's, and the various trends that grew out of this merger. These trends include the incorporation of psychoanalytic and developmental concepts interfaced with a comprehensive language and philosophy of movement.

Section B of Unit II looks at how the original east and west coast trends developed to influence an entire second generation of dance therapy leaders. The contributions of these "new" leaders are identified and reviewed. For example, aspects of Jungian analysis, ego psychology and object relations theory, psychodrama and Gestalt Therapy, and the graphic arts were all being actively explored and incorporated into the theory and/or practice of dance therapy. Dance therapy, once primarily strong in its practical applications and methodology, was developing theoretically and philosophically in the late 1960's and 1970's. During this period, the proteges of the pioneers were also refining and expanding upon the contributions of their mentors. Dance therapy was emerging as a cohesive and integrated discipline.

Unit II concludes with the clinical applications of dance therapy literature. It shows, for example, how dance therapy can be effective with individuals with eating disorders, victims of sexual abuse, disturbed children and families, hospitalized psychiatric patients, normal and neurotic adults, brain injured and physically handicapped patients, the elderly, and others. To illustrate various approaches, case studies accompany a discussion of theory and practice. In this section, the versatility of the discipline is explored. Like verbal psychotherapy, the techniques and theory vary tremendously to meet the needs of the individual.

Unit III reports on the results of a 1985–1986 survey of 100 leaders in the field, members of the Academy of Registered Dance Therapists. This designation means that the ADTA recognizes these individuals as qualified to teach, supervise, and conduct a private practice. From the responses to this survey, the author has compiled a "Who's Who" for the dance therapy profession. This information will be made available by the publisher to interested readers. The survey is used as a guide in assessing trends in the field. Included is an analysis of the dance backgrounds of the respondents, with an assessment of the importance of such areas as choreography, performance, and teaching on their careers. The respondents' training in psychology is also examined, including an analysis of the psychological frameworks most useful to dance therapists today. The results of the survey are useful in tracking the development of dance therapy as a whole.

This text is an attempt to synthesize the evolution of dance therapy, from its inception through its current scope and direction. The text provides detailed accounts of the theoretical and practical developments in the field, and integrates important concepts borrowed from dance, psychology, the body oriented therapies, and nonverbal communication research. It is the hope of the author that this text will provide readers with an in-depth understanding of the dynamic discipline of dance therapy.

Foreword

In this book Dr. Levy treats the reader to an all-encompassing view of the field of dance/movement therapy. It is a historical and chronological description of the profession, as presented in the published and privately circulated literature of the six major pioneers in the field and their followers and proteges. The results of a training and education questionnaire completed by registered dance/movement therapists is also included. Dr. Levy has paid meticulous attention to presenting this material in a conscientious and painstaking manner. In so doing, she has compiled a very thoughtful, thoroughly researched, and comprehensive book about the dance/movement therapy profession.

This book can be seen as a manual or text of dance therapy. The material is presented in three sections. First, the work of the six major pioneers, Marian Chace, Blanche Evan, Liljan Espenak, Mary Whitehouse, Trudi Schoop, and Alma Hawkins is presented. The next section is devoted to developments of the field during the late 1960's through the 1980's, including the introduction to the United States of Rudolf Laban's theories on movement and movement analysis and its subsequent effect on dance therapy. The last section provides the results of the dance/movement therapy questionnaire, along with a linear perspective of the descendants of the pioneers. The survey results reveal some important trends for the future of dance therapy.

Dr. Levy has delineated in rich detail the background, education, and training of each of the six dance therapy pioneers. They all believed and experienced that dancing had profoundly affected and changed them. They all used their dance backgrounds—as teachers, choreographers and performers—and their knowledge of psychological theories to form a new calling. In essence, they looked to psychological theories to affirm what they already intuitively knew and understood regarding the effects of dance on people. From this amalgam of two theories sprung dance/movement therapy. The historical context of the book also allows for the speculation that the sites and populations with whom the pioneers chose to work created the development of their particular dance/movement therapy theories and techniques.

Invaluable to all in the profession is the re-emergence here of original work published in books and articles now out of print and perhaps even forgotten. This book, *Dance/Movement Therapy*, will serve all levels of practitioners, students, and academicians as well as those in the graphic and performing arts. Practitioners will find the book useful for refreshing their memories about the roots of dance therapy. Students will have all the dance/movement therapy theories and trends in one book and will have a better appreciation of the history of the field. Artists will further explore the interest values of their art. Finally, of course, academicians will have available an all-inclusive textbook.

Elissa Queyquep White, ADTR, CMA
Charter Member, American
Dance Therapy Association
Co-Founder, Dance Therapy
Masters Program, Hunter College

Introduction

Dance therapy, the use of dance/movement as a psychotherapeutic or healing tool, is rooted in the idea that the body and the mind are inseparable. Its basic premise is that body movement reflects inner emotional states and that changes in movement behavior can lead to changes in the psyche, thus promoting health and growth. Helping individuals—those who are generally healthy as well as those who are emotionally or mentally disturbed, physically or mentally disabled—to regain a sense of wholeness by experiencing the fundamental unity of body, mind, and spirit is the ultimate goal of dance therapy.

The use of body movement, particularly dance, as a cathartic and "therapeutic" tool is perhaps as old as dance itself. In many primitive societies, dance was as essential as eating and sleeping. It provided individuals with a means to express themselves, to communicate feelings to others, and to commune with nature. Dance rituals frequently accompanied major life changes, thus serving to promote personal integration as well as the fundamental integration of the individual with society.

> The dance of medicine man, priest or shaman belongs to the oldest form of medicine and psychotherapy in which the common exaltation and release of tensions was able to change man's physical and mental suffering into a new option on health. We may say that at the dawn of civilization dancing, religion, music and medicine were inseparable. (Meerloo, 1960, pp. 24–25)

In contrast, the complexity and stress of modern living have led many people to feel alienated, out of touch with themselves, with others and with nature. Much of Western thought at the turn of the century subscribed to the credo of dualism, or the distinct separation of body and mind. Formal dance developed as a performing art, emphasizing technique, with little attention to how it affects the dancer. Medicine and psychotherapy developed as forms of treatment, with the former focusing on the body and the latter focusing on the mind. Psychotherapeutic treatment approaches were almost entirely verbal and non-active.

During the first half of the 20th century, a trend began within many fields to break away from the limitations of these traditions. The modern dance movement sought to replace the rigid and impersonal forms of the art with more natural, expressive movements emphasizing spontaneity and creativity. In the area of psychotherapy, there was a growing interest in the nonverbal and expressive aspects of personality. Out of this changing intellectual climate, dance therapy emerged in the 1940's and 1950's.

The Modern Dance Movement and Dance Therapy

Dance therapy can trace its earliest roots to modern dance in the early 1900's. Almost all of the major dance therapy pioneers began their careers as accomplished modern dancers. It was their experiences as performers and teachers that led them to realize the potential benefits of using dance and movement as a form of psychotherapy.

The modern dance movement was a reaction to the social and intellectual climate of the time, as well as a rebellion against the established forms of the art. In politics, the arts, and society at large, there was a movement afoot to liberate the person, to examine the full range of human behavior and the motivation behind it.

In early 20th century America two types of dance were generally, though not exclusively, performed—ballet (in limited quantity) and show dancing. The most prevalent form of dance was the latter—what Ted Shawn has described as "chorus girls kicking sixteen to the right, sixteen to the left, turning a cartwheel and kicking the back of their heads" (Mazo, 1977, p. 18). Show dance, while popular, lacked content and was not considered a serious art form. Ballet, although recognized as art, had deteriorated, some believed, into empty technical display by the late 19th century.

The stage was set for the birth of a new art form, one that would help audiences organize and integrate their current experience. It was no accident that modern dance pioneers turned for inspiration to classical Greek theater, which had been designed to help audiences experience emotional catharsis (Mazo, 1977).

It was not enough, however, to simply add emotional content to the movement. It was necessary to connect the personal expression of the dancer to more universal insight about the human condition. It is the universality which holds the audience, and makes an artwork meaningful rather than self-involved.

> Even if we are . . . merely the spectators of the dance, we are still . . . feeling ourselves in the dancer who is manifesting and expressing the latent impulses of our own being. (Ellis, in Steinberg, 1980, p. 254)

The early pioneers of modern dance turned inward as they sought new forms of creative self-expression that communicated not only their own personal experience and inner emotional content, but also universal themes.

> Modern dance replaced the fading content of Western dance with certain key notions: spontaneity, authenticity of individual expression, awareness of the body, themes that stressed a whole range of feelings and relationships. The great pioneers of its early years personified themes of human conflict, despair, frustration, and social crisis. Frequently the choreography of the modern dancer crystallized into the age-old form of ritual. Such key innovations led directly to the essence of dance therapy. (Bartenieff, 1975, p. 246)

The revolution in dance was not an isolated event, but rather part of and consistent with revolutionary changes taking place in the overall intellectual climate of the late 19th and early 20th centuries. This was a time when new ideas and innovations were spilling over from various fields into others, creating a general environment of mutual influence, support, and inspiration.

One innovator who had significant impact on the modern dance movement and hence on dance therapy was Francois Delsarte (1811–1871), " . . . a quite extraordinary and fascinating Frenchman . . . who lurked behind quite a great deal of modern dance" (Fonteyne, 1979, p. 102). Delsarte had begun his career as an opera singer but lost his voice. He then devoted himself to researching and organizing a system of naturally expressive gestures for actors and singers to replace the superficial gestures and postures that dominated the theater during this period. His study of natural human movement led him to observe people in various walks of life doing everyday things. From his observations, Delsarte formulated laws he believed governed people's unconscious, expressive movement, and employed these laws to interpret behavior. His work profoundly influenced not only his former profession, opera, but also dancers and other performing artists.

Among the dancers who were influenced by Delsarte was Isadora Duncan (1878–1927). Building upon Delsarte's work, Duncan turned to the expressive gestures used in ancient Greek theater in her attempt to build a new dance vocabulary.

Isadora Duncan is referred to by some as the original pioneer of modern dance in the United States. According to Schmais, a major dance therapy leader, it was Duncan who

> . . . was the first to break away from the stultifying structure of classical ballet and champion dance as the emanation of emotions in harmony with external forces of the natural world. She saw dance as man's most fundamental response to the universe; reviving man's capacity to dance was the means through which his ability to live fully and freely could be renewed. (Schmais, 1974, pp. 7–8)

The work of Sir James George Frazer in the field of anthropology also had a major impact on the modern dance movement. The publication in 1890 of his book *Golden Bough*, which examined the role of ritual dance in primitive cultures, created an anthropoligical revolution which added more fuel to the dance revolution and hence to the emergence of dance therapy. Primitive ritual became a source of inspiration for modern dance, as the older concept of dance as an expression of magic, religion, and spirituality was revived.

Chief among dancers who explored this spirituality was Ruth St. Denis. St. Denis, an American performer, looked to Eastern cultures for the spiritual ideas she could not find in the United States. Eastern dance styles provided her with themes, costumes, and characters through which to structure and objectify her personal search. St. Denis, along with Ted Shawn, formed the Denishawn school of dance which promulgated the developing concepts and techniques of modern dance. Many future stars began at Denishawn, including Martha Graham, Doris Humphrey, and Charles Weidman. Moreover, Marian Chace, the major pioneering dance therapist in the United States, was a Denishawn disciple.

During the same time that modern dance was emerging in the United States, a similar dance revolution was fomenting in Europe. Led by Mary Wigman (1886–1973), the revolution centered in Germany. Perhaps driven by the need to give form through movement to the events of the time, Wigman pioneered a dance style that was strong, direct, and austere in its communication with the audience. Margot Fonteyne (1979) describes Wigman's performances as "intense, concentrated, bare presentations, so pared down to the pure essence of personal expression that they appealed only to a very serious and dedicated audience" (p. 110). Among this "serious and didicated audience" were several of the original dance therapy pioneers: Mary Whitehouse, Franziska Boas, and Liljan Espenak in particular, as well as Trudi Schoop, Elizabeth Polk, and later, Irmgard Bartenieff and Rhoda Winter Russell.

John Martin (1972), movement critic, historian, and author of *The Modern Dance* (1933) says the following about Wigman:

> At its highest point of development we find the so-called expressionistic dancing with Mary Wigman as an outstanding practitioner. This class of dance is in effect the modern dance in its purist manifestation. The basis of each composition . . . lies in a vision of something in human experience which touches the sublime. [Martin refers to Wigman's work as in

Bird Larson's students in performance. (Photo courtesy New York Public Library.)

> part metakinesis.] Its externalization . . . comes not by intellectual planning but by feeling through with a sensitive body. The . . . result . . . is the appearance of entirely authentic movements which are as closely allied to the emotional experience as an instinctive recoil is to an experience of fear (pp. 56–60).

This picture of Wigman's dance as authentic movement in its purest form was picked up on by Mary Whitehouse and has become the insignia for a large portion of dance therapy on the west coast. This concept, as Martin points out, was the essence of the entire modern dance movement spawned by Wigman in the early 1900's and carried to its therapeutic potential in the discipline of dance therapy.

Mary Wigman was a colleague and student of the movement philosopher Rudolph Laban. Laban's contribution was both theoretical and analytical, offering structure and analysis of movement in an unstylized teaching technique. Wigman also studied eurythmics (i.e., the representation of musical rhythms in movement) with Swiss musician Emile Jacques-Dalcroze, and was, like Duncan, a student of Delsarte. She incorporated these progressive teachings, all of which had in common natural expressive movement, and created her own style of teaching dance. Its major requirement was that the student find his/her own unique style, once given the elements of dance upon which to build. That is, Wigman's movement medium was expressive/improvisational. Her technique provided a strong foundation for exploring human emotion, both personal and universal.

In the 1920's, Wigman's counterpart in improvisational and expressive movement in America was Bird Larson. Larson's major contributions to modern dance are not well known today due to her premature death in the 1930's. However, those who studied with her were profoundly influenced by her (see Evan, Chapter 2, and Boas, Chapter 8). Early on at Barnard College and Columbia Teachers College in New York she referred to her work as "Natural Dance" and later, when she opened her own studio, it was called the "Larson School of Natural Rhythmic Expression." Her improvisational work was closely related to that of Wigman. Moreover, after hearing about Wigman in the late 1920's, Larson decided to visit her school in Germany. From this visit Larson brought back Wigman's use of percussive instruments as a facilitator for her already developed natural rhythmic dance techniques. The similarities between the improvisational dance technique of Wigman and those of Larson are especially significant in light of the fact that each had a profound and lasting impression on major dance therapy pioneers. The expressive opportunities which both Larson and Wigman afforded their students in the 1920's can be viewed as some of the earliest forms of dance therapy in the 20th century.

This focus on individual self-expression and exploration has sometimes been referred to by dance therapists and modern dancers as contacting one's "inner dance." Encouraging the development of the inner dance was likened by many to encouraging the uncovering of the unconscious through body movement.

The overall intellectual climate of this early period revolved around the acceptance of the unconscious in man as a potent source for deepening self-realization and reflection. The revolutionary work of Sigmund Freud in psychology, first introduced in the late 19th century, made a great impact on modern dance and dance therapy. Freud's work prompted an examination of the motivation behind human action, in contrast to the 19th century attitude that intense emotions were to be concealed. The innovative belief in the open expression of feeling gave dance both fresh subject matter and structure.

By the 1930's and 1940's, at about the same time psychoanalytic thought (the work of Freud, Adler, Jung, and others) was gaining wider acceptance, the concept of the inner dance was becoming popular among modern dancers. While psychoanalysts were encouraging the expression of the unconscious through verbalization, dancers began to use body movement as the vehicle for similar forms of expression.

The writings of the early modern dancers in America clearly reveal the deep attention paid to the unconscious and the dream self. Some, like Martha Graham, attended to thoughts, feelings, and insights from the unconscious and included these in their teaching and choreography. Others, like Mary Whitehouse and Marian Chace, were so moved by the interaction of psyche and soma through dance movement that they left the performance and choreography aspects of dance and focused exclusively on the psychotherapeutic aspect of dance. The environment was ripe for the translation of self-expression through the dance into "psychotherapy through the dance," that is, dance therapy.

When dance therapy began in the 1940's, its practice was limited primarily to the back wards of mental hospitals. By the 1950's, another branch of dance therapy was beginning to emerge. As a result of the natural integration of dance with self-expression, some former dance performers and educators found themselves practicing dance therapy in their private studios. A few of these private practitioners began functioning as primary therapists utilizing dance therapy with normal and neurotic individuals.

The dance therapy pioneers brought with them from their earlier modern dance experience a nonjudgmental attitude toward individual movement preferences, stressing development of one's own expressive style, and an emphasis on personal expression through uninterrupted improvisation. This legacy from the modern dance movement formed the foundation upon which each pioneer built her dance therapy practice, in accordance with the needs of the population she treated and the setting in which she worked. By the end of the 1950's, dance therapy was already utilizing a broad spectrum of intervention styles. In addition, the rudiments of dance therapy theory began to emerge during this period.

As the dance therapy pioneers continued to explore the power of dance/movement as a form of psychotherapy, they began to seek further understanding of the nature of personality and the effects that dance had on personality. This led them to investigate existing theoretical frameworks, particularly in the field of psychology, which gave expression to their own intuitive knowledge and supported their dance therapy practice. Thus, the discipline of dance therapy evolved in the 1940's and 1950's out of the merger of the modern dance movement with existing theories of group and individual psychology and psychotherapy.

Influences on Dance Therapy from Other Fields

The overall focus in the field of psychology during the first half of the century was on the use of verbalization as a medium for the expression of the unconscious. Nonverbal treatment approaches, including dance therapy, were not yet generally accepted. Nevertheless, included in the overall work of many psychological theorists and clinicians during this early period were concepts and techniques that helped to lay the foundation for the later development and recognition of nonverbal treatment approaches. The following is a brief review of the major theoretical frameworks which influenced the work of the dance therapy pioneers and continue to have an impact on today's dance therapy.

Although Freud did not stress nonverbal expression as a treatment method, he did recognize the connection between the body and emotions, as well as the relationship between psychoanalytic thought and nonverbal communication:

> He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If the lips are silent, he chatters with his finger tips; betrayal oozes out of him at every pore. And thus the task of making conscious the most hidden recesses of the mind is one which it is quite possible to accomplish. (Freud, 1905, pp. 77–78)

In addition, Freud believed that conflict, with its resulting mechanisms of defense and repression, is the responsibility of the ego, which is "... first and foremost a body-ego" (Freud, 1923, p. 31).

Wilhelm Reich, an Austrian psychiatrist and psychoanalyst, was one of the first clinicians with a nonverbal orientation. In the 1920's, he began intensive studies of his patients' psychosomatic expressions in an effort to clarify the connections between the somatic and psychic realms. Reich discovered that while some patients were capable of verbalizing thoughts and feelings, others developed defenses, or "armor," which were rooted in the body in the form of muscular tension. "Every increase of muscular tonus in the direction of rigidity indicates that a vegetative excitation, anxiety or sexuality, has become bound up ..." (Reich, 1949, p. 342).

Reich introduced the use of muscular manipulation to overcome armoring and thus facilitate the release of repressed psychological material. His use of the body in therapy was controversial at that time, but was later popularized by Alexander Lowen in the 1960's.

Carl Jung's theory of active imagination brought attention to the therapeutic value of the creative act. He believed that fantasies and feelings from the primitive unconscious can be evoked and symbolically manifested in artistic experiences. This concept supports the work of dance therapists, who use dance/movement—particularly the creative act of dance/movement improvisation—to help individuals express the unconscious. Mary Whitehouse, a major pioneering dance therapist who integrated Jungian concepts into her work, ushered in the branch of dance therapy often referred to as "movement-in-depth—a Jungian approach to dance therapy."

The work of American psychiatrist Harry Stack Sullivan has also been significant for dance therapists. His interpersonal theory of personality evolved from the need to understand pathology within its cultural and interactional context. He believed that individuals develop personality characteristics and a sense of self through their interactions with their surroundings and through their perceptions of those interactions.

Sullivan (1962) is also known for developing a therapeutic methodology with schizophrenics that focused on accepting them at their own developmental level and interacting with them at this level. Most of all he accepted them as equal human beings who could benefit from genuine communication with others. Sullivan's influence on dance therapy can be seen in the work of Marian Chace. Chace viewed dance therapy as a vehicle for direct communication with patients. Through the "therapeutic movement relationship" she was able to engage severely withdrawn psychotic patients in verbal and nonverbal interactions. It was this form of heightened communication and interaction that Chace excelled in and taught to her dance therapy disciples.

Alfred Adler's chief contribution to psychology was his belief that the aggressive drive is as important an influence on feelings, thoughts, and behavior as the libidinal drive. He emphasized that children and adults need to feel a sense of strength, competence, and mastery of their environment if they are to become an integral part of society and to master inherent childhood feelings of inferiority. Blanche Evan and Liljan Espenak, two major dance therapy pioneers, believed that Adler's work supported the use of body movement in treatment. Individuals who could learn to use their bodies in assertive, confident, and competent ways,

Ted Shawn and Ruth St. Denis, 1920's. (Photo courtesy New York Public Library.)

expressing feelings of independence and autonomy, would be able to more easily express such self-reliant behaviors and attitudes in other aspects of their lives.

Paul Schilder's (1950) study of the body image, an important concept in dance therapy, examined within a psychoanalytic framework the relationship between movement and the impressions of the senses. He believed that the mental image, or topography of the postural model of the body, which is instantly being constructed and destroyed, forms the basis of emotional attitudes toward the body. According to Schilder, all movement activities serve to build a stronger body image.

> There is so close an interrelation between the muscular sequence and the psychic attitude that not only does the psychic sequence connect up with the muscular states, but also every sequence of tensions and relaxations provokes a specific attitude. When there is a specific motor sequence it changes the inner situation and attitudes and even provokes a phantasy situation which fits the muscular sequence. (Schilder, 1950, p. 208)

Schilder was part of a group of clinicians and researchers who were experimenting with verbal and nonverbal uses of projective methods at Bellevue hospital in the 1940's.[1] Members of the group included Lauretta Bender in psychology, Franziska Boas in dance therapy, Margaret Naumberg in art therapy, and Adolf Wollman in puppetry. Other pioneers in this area included Sidney Levy, Karen Machover, Henry Murray, and Bruno Klopfer. Levy worked at Northport Hospital, Long Island, and at the Veteran's Administration Mental Hygiene Service in New York. Specializing in the symbolism of animal drawings, Levy taught projective technique in New York University's clinical psychology program from the 1940's through the 1960's. At Kings County Hospital, Machover specialized in figure drawing as a projective technique. Murray developed the Thematic Apperception Test in his work at Harvard University. Klopfer, known as the "Father of the Rorschach," wrote the first textbook in America on the Rorschach test. The kind of courses being taught and the ideas being explored at that time are typified in the title of one of Levy's courses at New York University: "The meaning of animals as symbols in dreams and drawing, literature and legend, ritual and religion, art and projective techniques."

The projective technique, a creative and exploratory style of intervention, was an integral part of the creative dance movement (a branch of modern dance) and was commonly used by the pioneering dance therapists to facilitate expression and insight. For the dance therapist, the projective method is a natural extension of the dance experience.

In addition to existing psychological theories and techniques which influenced and encouraged the early development of dance therapy, there were other sources of support as well. Research concerning the nature of nonverbal communication and the relationship between the body and the mind added validity to the use of dance/movement as a psychotherapeutic tool.

The first comprehensive study of nonverbal behavior, unparalleled in its human and animal insights, was Charles Darwin's *The Expression of the Emotions in Man and Animals* (1872), which defined the evolutionary aspects of facial and body expression. This inquiry into form, significance, and action patterns led Darwin to postulate that expressive behavior, like physical structures, had survival value for the species. His research revealed that body movements not only had biological significance, as had previously been believed, but also had a correspondence with emotional expression.

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[1] The projective method "seeks to gain information indirectly through the use of . . . techniques . . . designed to provide opportunity for self-expression without verbal accounting" (Campbell, 1981, pp.. 386–387). These techniques are purposely unstructured and often evocative. The individual is encouraged to express the complexities of his own personality through various idioms.

Some researchers in the field of psychology further explored the link between the mind and the body. Their research focused mainly on gesture and posture and their associated emotional content.[2]

Despite this early interest and research in nonverbal communication, treatment which stressed nonverbal approaches did not gain wide acceptance until the 1960's and 1970's. This change in attitude came about gradually, perhaps due in part to the loosening of post-World War II societal restrictions, the continuing growth of modern dance and psychoanalytic thought, and the dissemination of Eastern philosophies emphasizing the unity of body and mind. In addition, after a long hiatus, there was a new wave of interest in the nonverbal domain in the 1960's and 1970's, bringing attention back to earlier research in the area and inspiring new research.

The flourishing of nonverbal communication research during this period benefited dance therapy significantly. It brought new recognition to the importance of body movement in psychotherapy. It also provided a recognized methodology and terminology for researching and observing the meaning of movement behavior and the interconnection between movement and emotional expression.

Ray Birdwhistell (1952, 1970), an anthropologist and renowned nonverbal communication researcher, is credited with establishing a new discipline, kinesics, which is the study of structural units of movement in relation to social processes. His work spawned a new wave of scientific and therapeutic research that studied movement within a cultural context, linking movement patterns to speech patterns and interactional systems.

Albert Scheflin (1965, 1973), a psychiatrist, related the study of kinesic units to psychotherapy research. Using a communications model similar to Birdwhistell's, including both verbal and nonverbal components, Scheflin analyzed the variety and complexity of body movements that take place in a therapeutic session.

The work of William Condon and his associates (1963, 1964, 1966, 1967a, b, 1968, 1969, 1974) focused on interactional synchrony and self-synchrony, detailing the order and rhythm of human behavior. His research has influenced dance therapy with autistic children. Adam Kendon (1970) also researched interactional synchrony, and documented the organizational hierarchy of gesture and speech.

It was not uncommon for nonverbal communication researchers to use dance metaphors when describing the rhythmic flow inherent in human interactions. For example, Kendon made the following observation:

> The listener dances with the speaker to show he is with him, receiving him. He then gets the speaker to dance with him as a way of heightening the synchronization [communication and rapport] between them. . . . (Costonis, 1978, p. 23)

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[2] See, for example, Ferenczi (1916), Deutsch (1922, 1947, 1951, 1952), Fenichel (1928, 1934), Krout (1931, 1937) and Malmo (et al., 1950, 1951, 1956, 1957).

A movement choir directed by Mary Wigman, 1920's. (Photo courtesy New York Public Library.)

Complementing the resurgence of nonverbal communication studies in the 1960's and 1970's was the flourishing of new forms of therapeutic treatment.[3] Among these were the humanistic psychological approaches, the action-oriented psychotherapies (which include dance therapy) and the body therapies, all of which have had varying degrees of theoretical and practical influence on dance therapy.

The humanistic movement spearheaded by Carl Rogers (1951, 1961) and Abraham Maslow (1962, 1970) took a non-analytical, non-judgmental, and anti-diagnostic approach to mental disturbances, and posed questions that transcended the traditional survival approaches to psychological adaptation. Rogers and Maslow inquired into the processes that motivate people to aspire, excel, create, and fulfill human potential. Humanistic theory's major contribution is in its emphasis on the uniqueness of individuals, and on methods of releasing humanity's creative and expressive potential. In essence, this so-called "third-force" in psychology seeks out the health and potential in the personality rather than pathology and weakness and in so doing opens the doors of expression to many different idioms—dance, drama, music, art, and so on. Alma Hawkins, a major dance therapy pioneer, is among those dance therapists who have incorporated humanistic theory into their work.

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[3] While some of these first emerged at this time, not all were "new." Some, like dance therapy, had developed earlier but did not gain popularity and acceptance until this period.

Another form of psychotherapy which has achieved prominence during the last few decades is the action-oriented psychotherapies. These include the creative arts therapies (dance, drama, music, art, poetry, etc.), psychodrama, gestalt therapy, psychomotor therapy, and bioenergetic therapy.

The action-oriented psychotherapists acknowledge that thoughts and feelings are expressed and processed on many levels and that not everyone can benefit from formal psychoanalytic or strictly verbal methods. Therefore, they provide a milieu in which the individual is able to explore emotions through a combination of verbal and psychomotor methods.

One of the goals of the action-oriented psychotherapies is to integrate the body and the mind through the use of action techniques and projective psychological methods. One concept which unites these therapies is the belief that involving the body and musculature in the therapeutic process evokes unconscious psychological material and deeply held emotions. The action-oriented psychotherapist then structures the newly released material via drama, dance, art, and/or writing to bring about deeper psychophysical awareness, catharsis, and possibly insight.

One of the earliest of the action-oriented psychotherapies was psychodrama, developed by J. L. Moreno. Working within a group therapy structure, Moreno utilized the group process and group interaction to create and guide dramatic dialogues centered on the verbal and nonverbal acting out of feelings on the psychodramatic stage. He emphasized the use of therapeutic role-playing and role reversal, techniques which he originated.[4]

Some of the acting-out and role-playing techniques of psychodrama were incorporated into the work of Frederick S. Perls (1947, 1971, 1972), the founder of Gestalt therapy, and Albert Pesso (1969, 1973), who developed his own form of psychomotor therapy. Perls, in contrast to Moreno, placed more emphasis on the individual within the group than on the group's interaction. In addition to role-playing techniques, Perls also used other methods such as visualization, imagery, and attending silently to the body. In contrast, one of Pesso's contributions was his utilization of the rhythmic expression of emotions within structured dramatic formats. As a former dancer, he understood the power of rhythmic activity and movement expression.

Alexander Lowen (1967, 1975) founder of bioenergetic therapy and disciple of Wilhelm Reich, differed from the other action-oriented psychotherapists in that he placed less stress on artistic structure (e.g., complex dramatic enactments and sublimation through shape and form), and instead emphasized the use of specific physical exercises based on Reich's theories. These exercises, he believed, released emotions and thus facilitated more meaningful verbalization.

Dance therapists incorporate some of the same techniques and theories as the action-

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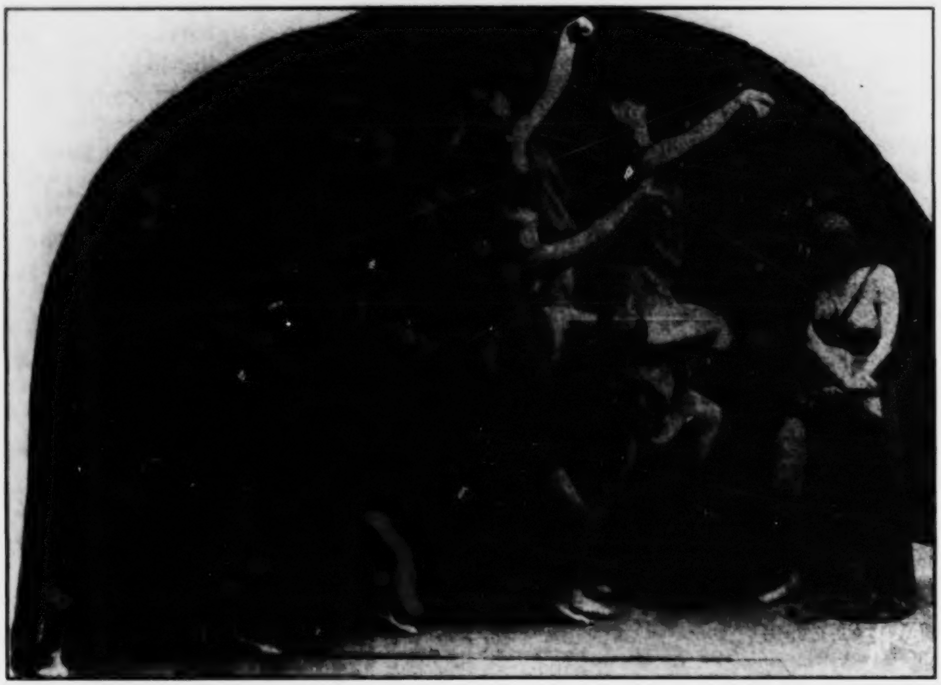
[4] It is interesting to note that Moreno brought psychodrama to St. Elizabeth's Hospital in the 1940's, at the same time that Marian Chace began her pioneering work there as a dance therapist. Though it is not known whether they worked together or influenced each other, there were remarkable similarities between these two pioneers. Each broke away from traditional, purely verbal treatment approaches and gave birth to a new approach to psychotherapy. Each utilized the performing arts, incorporating body movement, verbalization, and interaction, to deepen self-awareness and self-realization. Chace and Moreno were both uniquely gifted in their ability to conduct group therapy, using the group's dynamics to enhance and integrate the individual's experience of self.



Isadora Duncan, her dancers. (Photo courtesy New York Public Library.)

oriented psychotherapists decribed above. What differentiates dance therapy is its emphasis on the use of the dance/movement form, integrated with verbalization, as the primary expressive modality. More specifically, some dance therapists see the attributes and dynamics of dance and movement as uniquely suited for the expression of the unconscious along with id, ego, and superego expression, in addition to providing a framework for relationship building, and body image and personality development.

The various body therapies which have become popular since the 1960's also utilize methodologies which overlap with dance therapy technique. The title "body therapy" encompasses various forms of movement work aimed at achieving efficient physical functioning on a muscular and skeletal level. Muscular balance and skeletal alignment together provide the individual with a greater ability to relax and to use body energy with increased flexibility, awareness, and satisfaction.

The body therapies utilize methodologies of postural restructuring such as those developed by F. Mathias Alexander (The Alexander Technique) and Moishe Feldenkrais (1972, 1973), which stress self-awareness during movement, and those developed by Mabel Todd (1937, 1953) and Lulu Sweigard (1974), which emphasize the use of imagery and visualization. Relaxation methods, such as those originated by Edmund Jacobson (1929), and techniques of deep muscular massage, such as those originated by Ida P. Rolf (n.d.), focus on the release of psychophysical tensions in the musculature.

At various times these techniques have been incorporated into dance therapy theory and practice. Unlike dance therapists, however, body therapists take more of a teaching or directive role. Generally, they do not focus on or develop the psychological aspects of movement.

The flourishing of the various body therapies, action-oriented psychotherapies, and humanistic psychological approaches made available to individuals many different forms of therapeutic treatment. Their popularity, along with the new wave of nonverbal communication research during this period, added to the growing acceptance within the mental health community of action oriented and creative treatment approaches. This growing acceptance, however, was not in itself enough to bring dance therapy into the full light of professional recognition; it was up to dance therapists themselves to achieve this.

The Professional and Institutional Development of Dance Therapy

As dance therapy entered the 1960's, it was still being viewed as a unique skill possessed by a few rare and gifted individuals rather than as an established profession. Although the dance therapy pioneers had made many inroads into the field of mental health and had built a solid foundation of dance therapy practice, they were, for the most part, functioning more as individuals than as members of a professional community. Having moved gradually and naturally from dance into dance therapy, many still thought of themselves as dance teachers and some were unaware of the existence of the many others who were doing work similar to their own.

While there was some dance therapy literature during this early period, the actual articulation of theoretical concepts was still sparse and was more often spread through verbal exchanges with these pioneers rather than through their writings. Little work had been done in the area of empirical studies and in the establishment of a theoretical framework which would serve to integrate the various aspects of practice.

Furthermore, there were no standardized requirements for the professional training of dance therapists and only limited training opportunities. Since academic institutions did not yet offer programs in dance therapy, students sought training through private apprenticeships with established dance therapists. In the late 1950's, independent training programs were offered by Marian Chace and Blanche Evan in New York, and Trudi Schoop and Mary Whitehouse in California. Stark (1980), referring to the training offered by Chace, Whitehouse and Schoop, states:

> Early training focused on the clinical application of dance therapy technique with little attention to the underlying principles or theories. In order to supplement their training, many students took courses in the social and behavioral sciences or enrolled in graduate programs . . . in the field of human behavior. (p. 14)

Professional training through private apprenticeships continued in the 1960's. Schoop and Whitehouse continued their work in California, and in New York, independent training programs were offered by Evan, Chace, Espenak, Bartenieff, and Rosen.

During the 1960's, as various action oriented treatment approaches, including dance therapy, were becoming more widely accepted, dance therapists came to realize the need to professionalize the field. With the establishment in 1966 of the American Dance Therapy Association, dance therapy took its first steps toward becoming a recognized and organized profession.

At its inception, the ADTA was headed by Marian Chace, and had 73 charter members (see Appendix). In that year a committee of the ADTA formalized the definition of dance therapy: "the planned use of any aspect of dance to aid in the physical and psychic integration of the individual" (ADTA, 1966). This was later revised in 1972 to read: "Dance therapy is the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual" (Moerman, 1976). This change in definition reflects the change that the image of dance therapy had undergone since its early development in the 1940's. By the 1970's, more dance therapists were viewing their work as the equivalent of traditional verbal psychotherapy, differentiated only by the fact that it incorporated dance and movement techniques along with verbalization.

In the late 1960's, professional training emerged through the establishment of undergraduate level courses in dance therapy at various universities and colleges. In addition to providing new training opportunities for dance therapists, this had the effect of educating the public as to the presence and function of dance therapy. However, it also further diffused standards of professional training and exacerbated the need to organize and synthesize a curriculum of theory and practice which could be passed on to the following generations of dance therapists.

In the 1970's, graduate level courses in dance therapy began to emerge. Individuals could earn a Master's degree in dance therapy by organizing their own independent study programs at several universities and colleges. During this time, formal Master's programs in dance therapy also began to appear. The first, offered at Hunter College in 1971, was founded by Claire Schmais, Elissa White, and Martha Davis and was funded by a grant from the National Institute of Mental Health.

The fact that graduate degree programs did not emerge until the early 1970's reflects the wide gap that separated the clinical practice of dance therapy, which had grown rapidly since the 1940's, and the theoretical development of the field, which had lagged behind. In 1974, Sharon Chaiklin, a former president of ADTA, wrote:

> Dance and movement therapy is still building its theoretical foundations. There is, however, enough knowledge to demonstrate that there now exists that specialized base which a profession requires. The development of a high quality curriculum is presently an urgent need of the dance therapy profession. (1974, p. 63)

The ADTA has encouraged the development of such a curriculum through its efforts to establish standards in graduate education programs in dance therapy. In 1973, Claire Schmais was appointed by the Board to the Ad Hoc Committee on Approval, which was responsible for establishing "Guidelines for Graduate Dance Therapy Programs" (Stark, 1980, p. 16). These guidelines were then used to establish standards of curriculum for graduate degree programs.

In addition to academic standards, professional standards of practice were being explored and formalized. In 1970, the first ADTA Registry Committee was established, consisting of three elected members: Elissa White (Chairperson), Susan Sandel, and Irmgard Bartenieff.

The general purpose of the Registry Committee was: a) to establish criteria for determining levels of professional competence, hence facilitating the hiring of dance therapists; b) to establish the ADTA as a professional organization with professional levels and standards; and c) to validate dance therapists' professional identity.

Another area in which dance therapy has significantly expanded its interests, concerns, and parameters, especially in the last decade, has been government affairs. The ADTA Government Affairs Committee has closely monitored government legislation and regulations relating to the profession and has initiated many actions and projects in this area (ADTA, 1978, 1979).

The ADTA is the single association devoted to organizing and professionalizing the field and practice of dance therapy. Over the last two decades, the Board of Directors, along with committee chairpeople and regional and chapter leaders (see Appendix), has worked to bring dance therapy to its present professional, educational, and organizational level.[5]

The professionalization of dance therapy has gone hand and hand with a rapid expansion of the field since the 1960's. Dance therapy is currently being used in medical and mental hospitals, clinics, rehabilitation centers, schools, and in private practice. Today's dance therapists function as primary therapists, as ancillary therapists, and as family and couples counsellors. They serve a wide spectrum of patients of all ages, from individuals with severe emotional and physical problems and handicaps to normal individuals seeking in-depth self-exploration through expressive movement. In short, dance therapy is moving into countless areas of mental health and continues to expand its education, practice, and organizational affiliations.

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[5] Space does not permit a comprehensive description of all the contributions made by the ADTA and its members, who now number more than 1,000. Further information about the Association and its activities can be obtained by writing to the ADTA at 2000 Century Plaza, Columbia, Maryland 21044, and by consulting the Appendix.

UNIT I

Early Development: The Pioneers of Dance/Movement Therapy

Foundations of the theory and practice of dance therapy were laid, in large part, by six major pioneers in the United States. Marian Chace, Blanche Evan, Liljan Espenak, Mary Whitehouse, Trudi Schoop, and Alma Hawkins developed a broad spectrum of clinical styles which contemporary dance therapists still use today.

This unit includes a comprehensive review of the work of these early pioneers. Section A discusses the work of Chace, Evan, and Espenak, and the development of their work on the east coast. Section B reviews the west coast pioneers: Whitehouse, Schoop, and Hawkins. The geographical delineation is not, however, an arbitrary one; distinct forms of treatment were being developed on each coast in the 1940's and 50's, and these differences have become the content for ongoing discussion and exploration of dance therapy practice and its effects on various populations. Section C discusses the emergence of dance therapy in the midwest, and reviews the literary contributions of Franziska Boas and Elizabeth Rosen. The first comprehensive dance therapy study, completed in 1957, is also discussed in this section. Unit I concludes with an outline depicting the state of the art of dance therapy by 1960, summarizing the breadth of practice initiated by the major pioneers.

SECTION A

Major Pioneers on the East Coast

1

Marian Chace

Marian Chace (1896–1970) is "The Grand Dame" of dance therapy. In addition to her pioneering work with psychiatric patients, Chace also made a major contribution through her teaching, serving as mentor to a large number of dance therapists, many of whom were later instrumental, along with Chace, in establishing the American Dance Therapy Association. Many of today's leading dance therapists originally were trained by Chace and continue to espouse her methods. As a result, the Chace influence is still having a tremendous impact on the field (see Dance Therapy Tree and Survey Results).

Chace began her dynamic career as a dancer, choreographer, and performer. She studied dance in New York in the 1920's with Ted Shawn and Ruth St. Denis at the Denishawn School of Dance and performed with their company.

> The broad and eclectic approach of . . . Denishawn at that time enabled the pupils to find their own way of moving and developed their own abilities as choreographers and teachers as well as performing dancers. One was never taught a particular way of moving without having it related to the folk culture from which it came. The combination of modified ballet forms, contemporary dance, Dalcroze and other technical forms developed body equipment to use flexibly for whatever ideas were to be developed. (H. Chaiklin, 1975, p. 2)

In 1930, Chace moved to Washington, D.C. and began her own Denishawn school, where she continued to teach the ideas and methods she so respected.

Although Chace was originally dedicated primarily to performing, her interest in teaching dance broadened over time. She found that many of the students who came to her were not at all interested in dance as a performing art. They were often awkward and slow in class yet were persistent in their attendance. Chace was at first thwarted by their learning difficulties and puzzled by their enduring interest in the art of dance. She wrote:

> Out of observing the non-verbal communication of individuals taking their first classes, I began to understand and meet the needs for which they were asking help. Instead of feeling frustration when they lagged behind the more adequate pupils, I tried to empathize with them as people.
>
> Obviously, my teaching was undergoing change. Unconsciously, my centering for all pupils, became a support of them as people as well as dancers. While the students at the

> school found satisfaction in various ways, I think of the whole period of the 1930's for me as one of intense absorption in learning about non-verbal communication. (H. Chaiklin, 1975, pp. 15–16)

In the 1940's Chace began experimenting with dance therapy, though this formal title was not yet used. She worked as both a therapist and a trainer, teaching her techniques to the staff where she worked, a school for rejected children and later a training school for girls. In 1942, she started working as a volunteer at St. Elizabeth's Hospital in a program then called "dance for communication" (H. Chaiklin, 1975, p. 12). A year later she began work on salary with the Red Cross using dance action with servicemen. Throughout this period,

Marian Chace. (Photo courtesy the Marian Chace Fund, American Dance Therapy Association.)

Chace continued in dual roles, as a therapist and as a performer. She was once quoted as having said, "When I was at the hospital, I felt needed at the studio, and when I was at the studio, I felt needed at the hospital" (H. Chaiklin, 1975, p. 13).

Also during this period Chace was experimenting with the effects of music on patients. She was called by some a "music therapist" as well as a "dance therapist." Perhaps this derives from her Denishawn training, where music was emphasized. St. Denis had developed "music visualization," a process by which the specific qualities of the music were communicated through the movement, as well as the "synchoric orchestra," a technique in which each dancer would represent an instrument of the orchestra and move when that instrument played.

One can see the Denishawn influence in several other aspects of Chace's dance therapy work. For example, her background in folk dance steps and structures (such as the circle) was used by Chace to promote social interaction among her patients. In addition, her Denishawn training in production and performance was utilized in "The Hotel St. Elizabeth" (H. Chaiklin, 1975, p. 87), a theater piece written and produced by her patients at St. Elizabeth's Hospital.

The words of Dr. Jay Hoffman, a physician at St. Elizabeth's Hospital, illustrate the power of Chace's work and presence with psychiatric patients.

> As one watches these patients—very sick psychotic patients—and Miss Chace dancing, one gains the impression that through this medium the patients have at last found it possible to step out of their constricted world and quoting one of them, "to reach outward." Their movements seem free, easy, comfortable; they undulate, flow, and appear to express in motion or rhythm what they cannot express in words or in conventional social actions. That they can do this is a tribute to the unusual qualities of Miss Chace as a Dance therapist but it is also a reminder to us that there are few, if any, really "inaccessible" patients. (H. Chaiklin, 1975, p. 81)

In the mid-1940's Chace began giving lectures and demonstrations of her work outside of St. Elizabeth's Hospital. At one psychiatric facility, Chestnut Lodge, her presentation was so well-received that she was hired to work there in 1946 and remained there for approximately 25 years. In the early 1960's Chace started commuting to New York where she founded a landmark training program for dance therapists at the Turtle Bay Music School. Shortly afterward, she began spreading her ideas and methods in Israel in what proved to be a successful attempt at bringing her teachings abroad. In 1966, after helping to organize the American Dance Therapy Association, the "Grand Dame" of dance therapy became its first president.

Chace died in the summer of 1970. She left behind the art of using dance as a means of direct communication, expression, and interaction with those whom others could not reach. She also left behind her own unique group psychotherapy, a cohesive, complete, and self-contained system of treatment which creatively integrated verbal and nonverbal methods. For the dance therapists whom she taught, she left both a feeling of great respect, as well as some fear and trembling: she was an intense and complex woman. Those who could get past the complexity and could find *themselves* in the technique are deeply indebted (S. Chaiklin & Schmais, 1979).

Theory

The basic assumption that Chace made was that "dance is communication and this fulfills a basic human need" (Chaiklin & Schmais, 1979, p. 16). She was deeply influenced by Sullivanian theories. Sullivan also pioneered in his work with schizophrenics. His major stress was on respecting the schizophrenic patient as a unique individual, worthy of empathic rapport and capable of genuine interpersonal interactions. He viewed the schizophrenic as an individual like any other individual, yearning to be understood.

Chace also had a profound respect for the rights and needs of hospitalized patients. In addition, she had the intuition and skill to try various forms of verbal and nonverbal (i.e. dance and music) communication to reach patients. Others, who relied exclusively on verbalization to develop rapport, were often unable to establish contact with the patients assigned to Chace.

> In the psychotic, language loses much of its effectiveness as a means of relating to others, serving as a defensive barrier rather than a means of direct communication. The seriously ill mental patient relies to a large extent on nonverbal devices for the communication of his emotions. (H. Chaiklin, 1975, p. 71)

Believing that every patient had a desire to communicate, however buried that desire might be, Chace always sought after and engaged those parts of the patient's personality still available and wanting to "be heard and be well." In this respect, Chace was to the in-hospital patient in the 1940's what the humanistic psychologists Maslow (1968, 1978) and Rogers (1961) were to "healthy patients" in the 1960's. They believed in, respected, and engaged the healthy aspects of the individual.

Chace achieved this by closely observing and responding to the small idiosyncratic movements and gestures that constituted her patients' emotional expressions. Such direct movement expression, she believed, could break through verbal defenses. It is harder to disguise the physical expression of, or defense against, emotions than to hide their verbal counterparts. It was Chace's profound ability to use dance movement for self expression and communication and her capacity to perceive, encounter, reflect, and interact with the movement expressions of her patients that enabled her to draw them out of their psychotic isolation.

S. Chaiklin and Schmais (1979), proteges of Chace, organized her work into four major classifications: 1) Body Action; 2) Symbolism; 3) Therapeutic Movement Relationship; and, 4) Rhythmic Activity (to be referred to here as the Group Rhythmic Movement Relationship) (1979, p. 16).[1]

Body Action. The theory behind body action is well stated in this quote from Chace:

> Since muscular activity expressing emotion is the substratum of dance, and since dance is a means of structuring and organizing such activity (i.e., the expression of emotion), it might be supposed that the dance could be a potent means of communication for the reintegration of the serious ill mental patient. (H. Chaiklin, 1975, p. 71)

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[1] The following description of the "Chace Method" builds primarily on two prior publications: the S. Chaiklin/Schmais (1979) article and the writings of Chace which have been organized and published in an American Dance Therapy Association publication entitled *Marian Chace: Her Papers* (H. Chaiklin, 1975).

Although Chace rarely quoted theoretical ideas from Wilhelm Reich—and in fact would not have allied herself with Reichian technique—the theories inherent in her work presuppose the assumptions with which Reich was also experimenting in his own clinical work at that time (Reich, 1949). Chace and Reich paralleled each other historically and clinically, though Reich began in the 1920s. Both were experimenting with psychomotor therapeutic interventions as a way to unlock the thoughts, ideas, and feelings that they believed were held in the musculature in the form of rigidity.

> Through dance action, the patient gains motility of the skeletal musculature. Recognizing the body parts, breathing patterns or tension levels which block emotional expression, provides the therapist with clues to the sequence of physical actions that can develop readiness for emotional responsiveness; but it is not merely learning a movement which leads to change. The change occurs when the patient is ready to allow himself to experience the action in his body. (Chaiklin & Schmais, 1979, p. 17)

This parallels Reich's concept of the segmental arrangement of the body's armoring and his stress on the importance of the patient's readiness to experience his/her emotions (Reich, 1949). Also implied in this quote is the idea that physical/emotional rigidities and blocks can be seen by the perceptive and trained eye, as well as the concept that movement patterns reflect personality patterns and that when certain types of structural changes occur in body movement behavior, they are concomitant with certain changes in the personality. Again these concepts can be seen in Reich's emphasis on what he calls the identity of character and muscular armoring (Reich, 1949). In contrast, however, Reich did not use the dance form or stress an interactional approach—the mainstays of Chace's work.

Symbolism. The second classification, symbolism, describes the process of using imagery, fantasy, recollection, and enactment through a combination of visualization, verbalization, and dance action. Chace believed that problems could be worked through on a purely symbolic level and that interpretation or analysis was not always necessary for conflicts to be resolved. Through the power of movement, repressed and frightening emotions could be released in various forms, for example, patients taking the images of animals, flowers, and trees, as symbols of conflicts and dreams. Because the dance therapist accepts and empathizes deeply with the unconscious and frequently symbolic communications of the patient, the patient experiences a sense of deep trust and acceptance of his/her own expressive process. This, then, supports and encourages continued movement explorations.

The assumption inherent in the use of symbolism is that the release of the conflict and the resulting empathic support are of primary importance, and that this release can take place on many different levels and through many different forms. After the release, a feeling of acceptance is established and often the content behind the symbolic forms and images can more safely emerge into consciousness.

Therapeutic Movement Relationship. Chace had an unusual ability to kinesthetically perceive, reflect, and react to her patients' emotional expressions through her own body movements and voice tone. This concept of the therapist's involving herself in a movement relationship or interaction with the patient as a way of reflecting a deep emotional acceptance and communication was Chace's revolutionary contribution to dance therapy. The theoretical assumption in this process of "mirroring" or "reflecting" is simple—and perhaps this is why it is so effective. By taking the patient's nonverbal and symbolic communications seriously, and helping to broaden, expand, and clarify them, Chace demonstrated her immediate desire and ability to meet the patient "where he/she is" emotionally and thus to understand and accept the patient on a deep and genuine level. In essence, Chace said to her patients, in movement, "I understand you, I hear you, and it's okay." In this sense she helped to validate the patient's immediate experience of him/herself.

Group Rhythmic Movement Relationship. The power of group rhythmic action was used by Chace to facilitate and support the expression of thoughts and feelings in an organized and controlled manner. Even severely withdrawn patients could be mobilized by the contagious aspect of rhythm, with safe and simple rhythmic sequences providing a medium for the externalization of otherwise chaotic and confusing emotions.

Rhythm not only organized the expression of thoughts and feelings into meaningful dance action, but also helped to modify extreme behaviors, such as hyperactivity/hypoactivity, or a tendency toward the use of bizarre gestures and mannerisms. During the process of rhythmically exaggerating gestures and other nonverbal communications, Chace would elicit and even suggest symbolism and content. This would enhance the patients' awareness of their body language and its symbolic meaning, and gradually enable them to modify extreme behavior and even verbalize some of the underlying conflicts.

In essence, the group rhythmic movement relationship provided a structure in which thoughts and feelings could be shaped, organized, and released within the secure confines of both the rhythmic action and the group structure and support.

Methodology

The Chace technique is a unique, complete, and self-contained system of group therapy which utilizes dance movement as its predominant mode of interaction, communication, and expression. It is a complete system in that it has a beginning (warm-up), middle (theme development), and end (closure). Each phase has its own style of intervention and purpose.

The Chace Technique

I. Warm-up

- A. Initial contacts
    - 1. Mirroring
    - 2. Clarifying and expanding the movement repertoire
    - 3. Movement elicitation/movement dialogue.
- B. Group development—gradual formation of circle
- C. Group rhythmic expression/physical warm-up

II. Theme Development

- A. Picking up on nonverbal clues
- B. Broadening, extending and clarifying actions
- C. Use of verbalization and imagery
- D. Various other theme oriented possibilities (e.g. role playing, symbolic action, group themes)

III. Closure

- A. Circle
- B. Communal movement
- C. Possible discussion/sharing of feelings (H. Chaiklin, 1975)

The Chace warm-up was divided into three major parts: the initial contacts, the group development, and the group rhythmic expression/physical warm-up.

Warm-up: initial contacts

This first stage of the warm-up was an intuitive and often spontaneous process. The patients would enter the dance therapy room where they could choose, if they wished, to play music from a selection of records. Meanwhile, Chace would watch, experience, and interact with each patient, intuitively picking up the general tenor of the group. She had to move quickly in making contact with each patient, always keeping her senses available to the other patients, who might be moving alone or in small groups, so that they would never feel the lack of her presence. The goal was to establish direct communication and contact with the patients. She used this process to form the group structure as well as to keep it going.

The initial contacts took on certain specific intervention styles. The style Chace chose was determined by the emotional needs a specific patient projected at a given moment. For the purpose of clarification, the different intervention styles are here divided into three categories: a) mirroring or empathic reflection; b) clarifying, expanding, and broadening the expressive movement potential; and c) movement elicitation/dialogue movements. Although differentiated here, these categories were not always clearly delineated in practice. The needs of the patient would often require more than one style or an overlapping of several styles during a single interaction. For Chace, moving back and forth between these was as natural as the subtle shifts that take place in verbal dialogues. While these types of interaction were essential to the warm-up phase of the group, they also formed the core elements of the therapeutic movement relationship and thus were basic to all phases of the Chace Technique.

A. Mirroring or empathic reflection. This involved Chace's ability to kinesthetically and visually experience that which the patient was experiencing and trying to communicate. In essence, Chace would "mirror" or reflect back via her own muscular activity and verbal narration what she perceived and experienced in the body action and the body of the patient. To an onlooker, this could have been interpreted as mimicry—but it was more than that. Mimicry would be simply copying the form of the movement without incorporating its meaning. Mirroring of action and meaning, also referred to as kinesthetic empathy or empathic reflection, is one of the major contributions that Chace made to dance therapy.

B. Clarifying, expanding and broadening the expressive movement potential. In this approach, Chace began where the patient was, expressing the initial contact with the patient by mirroring, but then gently extending a certain gesture to clarify its focus or aim. Chace basically helped the expression to evolve into a more complete movement statement, thus enhancing the patient's identification and commitment to his/her own personal expressions and communications.

The following is an example of a movement intervention Chace made with a psychotic patient. The intervention used both empathic reflection (mirroring) as well as a dance movement response to the patient's physical manifestations of feeling.

> One patient stands hunched forward, contracted through the abdomen, his whole posture that of a person in terror. The therapist feels the tension within her own abdomen, and using this as a center of action, she develops a tension relaxation dance sequence. The original contraction she feels may be carried into an expansive movement or into some relaxed action neither of which can be construed as threatening. In either case, it must develop from or be closely related to the patient's own contracted movement. In his response to the therapist, the patient can carry his own contraction into a similar movement, and thus help himself to break away from his fixed emotional muscular pattern. When action with the therapist has been established, this patient may be able to move away from his spot into the room. Later he may be able to dance by himself, with another patient, or perhaps even during the same session, join the dance circle for short periods of time. (H. Chaiklin, 1975, p. 73)

In this example, Chace began at the point where the patient was, but then deciding that it would be better not to stay in this fixed state, she gradually and delicately led the patient into other options, always watching and observing to see the effect of the intervention. This concept of leading the patient into new and more varied movement configurations, as well as more clearly focusing or exaggerating initial movement patterns, is the basis of clarifying, expanding, and broadening the expressive movement potential.

C. Movement elicitation and dialogue movements. In this approach, Chace would interact with her patients, verbally and nonverbally, to elicit a movement response from them. For example, seeing a patient withdrawn in a corner, Chace might try to draw the individual out through initiation of a movement dialogue or role playing. She would perhaps, play the hurt child because the patient wouldn't "come out and play," or make an evocative movement in an attempt to elicit or "demand" a response from the patient. An example of the latter might be a pantomine of playing with an imaginary ball and throwing it to the still patient. The decision to use specific forms of play, music, and specific imagery to elicit movement dialogues was always based on the body expression of the patient.

The three different styles of initial contact discussed above serve to summarize, but do not cover all of the subtle styles of movement communication and interaction that Chace used. Chace described the initial contact phase of the warm-up process as follows:

> During this period, the therapist has the feeling of building multiple individual lines of communication, none of which may be neglected even momentarily, and all of which will gradually be developed into a group activity, away from herself except as a catalyst. . . . At

> the moment when the patient indicates that he is conscious of dancing with another person, rather than merely accepting another dancer moving in a similar fashion, his eyes will suddenly focus on the therapist and he will touch her hands, usually grasping them hard. I always respond with a simple "Hello." Patients who have danced in this fashion often say to me, "You have known me from the beginning." (H. Chaiklin, 1975, pp. 74–75)

This early part of the group process is analogous to an image of the therapist as the center of a wheel from which spokes radiate. As Chace moved with the group, she would connect and mobilize the people on the periphery. So, although she may have at one moment appeared as though she was involved with only one individual, she was in fact always attuned to the others, acting as the "hub" of the group, that is, the emotional turning point of all activity.

Warm-up: group development

After the initial contacts were made, Chace would begin the group development phase of the warm-up process, assessing the group's readiness to form a circle. Being sensitive to individual differences, Chace was flexible regarding group structure, aware that some patients would need more distance than others. Timing was very important. If she prematurely attempted to form the group structure, it would not succeed and if she waited too long, pandemonium could break out. It was understood that some patients might not be able to tolerate being part of the circle and so would participate from the sideline. Chace led from the circle itself as opposed to positioning herself in the center or outside.

> This section of the dance session starts gradually. . . . Small circles composed of varying individuals are forming, separating, and reforming. Leadership passes back and forth from members of the group to the dance therapist and her assistants. Movements begin to lose their bizarre quality, returning to it as the circle again dissolves into individuals using movements of their own. (H. Chaiklin, 1975, p. 76)

Chace viewed this part of the session as a "testing period" (H. Chaikin, 1975, p. 76). At this time, patients could feel their way into the group, testing whether or not they would be able to maintain their individuality and still feel comfortable within the group. The emphasis at this stage was on developing individual and group rapport in order to build trust and openness in the group.

Gradually, more patients would join and become part of the group process. Verbalization would become more prominent, complementing, clarifying, and broadening the group movement and interaction. Almost simultaneously, the group's movements would become more rhythmically synchronized. One could sense the patients' beginning to relax with one another.

Warm-up: group rhythmic expression/ physical warm-up

At this point, the group was, for the most part, in a circle, and some degree of group rapport had been established. Noticing certain physical tensions in the group, Chace might initiate a simple rhythmic movement, such as a stamp, possibly to the beat of a familiar folk tune. She would then gently guide the patients, through verbal narration and dance, into expressive movements which incorporated the chest, abdomen, and pelvic areas. In this way she gradually moved the group forward on two levels simultaneously, that is, developing group trust by initiating and facilitating activity that reflected group needs, and developing full body movement by gradually extending the dance action to include the entire body.

This extension of movement throughout the body helped to integrate the often fragmented sense of self in the severely disturbed individual. Other simple rhythmic movements such as swinging, pushing, or shaking were also used by guiding small movements into total body activity. The patient was encouraged to make a more complete commitment to and identification with his/her moving self. At this stage of the group process, Chace's movements were kept simple and easy, following rudimentary rules of movement so as not to confuse patients or scare them away from the group. This period of time also helped to bring in those group members still outside of the group.

The warm-up served other purposes as well. The movements aroused in the patients a sense of pleasure and enjoyment of body action. In addition, they helped to loosen the body and release excess tensions that could impede both the group process and the surfacing of emotional material. It is difficult to process emotions if the body is excessively tense.

Some preliminary emotional content would often emerge during the latter stages of the warm-up. Chace stated that it was not uncommon to hear patients make statements that expressed self-realization, such as "This is me," "I can live," or "These are my hands and these are yours" (H. Chaiklin, 1975, p. 76). Chace also noted patients expressing remorse at making personal discoveries long overdue—"This I should have known when I was a child," or awareness of despair and loneliness—"I never had a friend," "My mother never taught me to love" (H. Chaiklin, 1975, p. 76). These statements emerged spontaneously as part of the early group process. They were often spoken rhythmically, accompanying the group movements, and frequently evoked supportive group responses in either verbal or nonverbal forms.

While emotional themes did begin to crystallize during the warm-up process, they were not yet being dealt with in depth. Instead, the focus was on developing the rapport, trust, and physical readiness that would enable the group to support the deeper psychic material that might surface during the next phase of the group process.

Theme Development

Throughout the warm-up phase, Chace acted as a medium through which feelings in the group were picked up, processed, and reflected back verbally and nonverbally to the individual and the group. During the theme development phase, when the group was a stronger and more cohesive unit, she continued to act as a medium but with increased focus and clarity. With her patients' nonverbal communications as a starting point, Chace would use movement, verbalization, imagery, and various theme oriented actions to lead them into a deeper exploration of the effects, themes, and conflicts that she noted during the warm-up.

For example, the group might be involved in a simple side-to-side swing which one member appeared to be doing with an additional unconscious intention, as if he/she were saying in movement, "Get off my back." Perceiving this variation, Chace would facilitate its development in a number of ways. She could start by simply intensifying this variation in her own body, bringing it to the attention of the others, and then perhaps say a word or make a sound which would reflect the feeling she perceived. She would then encourage the group to relate to the emerging theme through continued use of rhythmic dance movement combined the use of sounds and words.

In order to further focus and clarify the meaning behind this variation she would present leading questions to the group such as "What is on your back?," "Do you imagine that you are talking to someone?," or "If there were something on your back, how would it feel or who would it be?" These questions often shed light on underlying conflicts and evoked material for further movement work.

At other times Chace might suggest a theme oriented movement pattern. Observing certain rigidities in a patient's upper arms and back, and realizing the patient's need to express anger via arm movements, she might suggest a symbolic action such as chopping. This would release emotional tension without overwhelming the patient's ego with a premature awareness of unconscious motivations.

Finally, Chace would use verbalization as a form of narration, to reflect, guide, and structure the group process. Through continual verbal narration, accompanied by dance movement and vocalization, she united the group and clarified its directions and intentions at all times.

Closure

Chace stressed the structuring of a supportive closure which would allow patients to leave with some sense of satisfaction and resolve. Sensing that the group interaction was about to reach a natural conclusion, she would bring participants back into the circle structure. In order to put closure on the individual relationships she would find some way to acknowledge all group members and conclude the session by utilizing repetitive "communal" movements that would provide the group with a feeling of connection, support, solidarity, and well being.

A communal movement might be a repetitive group movement such as holding hands and swinging together or coming together in a large swoop down and then raising hands high together in the center. The repetitive format supported a gradual slowing down of the individual expressive process and encouraged participants to shift their focus back to the group as a whole.

Closure also frequently included patients spontaneously sharing feelings, memories, and experiences verbally. Through this sharing, emotions were organized into meaningful verbal communication. Some patients had never before been able to experience such communication.

Summary

Chace was a brilliant pioneer and innovator in dance therapy. Although she worked at times individually, the power of her work was most clearly portrayed in the group sessions. The group method which Chace presented was sound, simple, and complete, with a natural progression from the individual to the group, and from one stage to the next.

As other pioneers are discussed in the following pages, there will appear to be a certain amount of overlapping of theory and practice. For this reason, it is important to summarize the major and unique contributions which Chace made to dance therapy. They are:

- the therapeutic movement relationship;
- the use of ongoing verbal narration as a form of reflecting the group and individual process;
- the use of rhythmic movement as an organizing and clarifying force; and
- the use of dance as a cohesive group process—a form of group psychotherapy.

2

Blanche Evan

Blanche Evan (circa 1909–1982) began her career in dance as a dancer, choreographer, and performer. For the last 30 years of her life, she was dedicated to the exploration of the use of dance as therapy. Evan was the originator of her own approach to dance therapy and was a pioneer in her emphasis on dance as a therapy for the neurotic urban adult.

Evan's petite body and graceful, delicate movements belied her intense, persevering, and outspoken nature. "She was a very complex and intense personality—very demanding, very giving, a fighter and an iconoclast—dissatisfied, yet hopeful, believing in basic human wholeness and possibility for each individual" (B. Melson, & A. Krantz, June 15, 1987, p.c.).

Evan's career was profoundly influenced by her dance studies in the 1920's with Bird Larson, one of the early practitioners of "natural dance" and expressive improvisational dance. Evan believed that Larson "was the most, and one of the very few objective teachers of that time, increasing skill yet preserving the health of the body, and opening the way for the individual student to express her own creativity in dance" (1980, p.c.). Devastated by Larson's premature death in the late 1930's, Evan became committed to carrying on and expanding upon her original teachings.

Evan was also influenced by the work of Dalcroze, Noverre, Stanislovski, and Mensendieck. She studied Spanish and Ethnic dance with Viola and La Meri (Evan, 1980, p.c.). However, her major interest was dance improvisation, that is, the dance as a medium through which one's creative and emotional potential could be drawn out and actualized (Evan, 1980, p.c.)

In the late 1940's and early 1950's, Evan's area of specialization was creative dance with children. Between 1949 and 1951, she published ten articles on this subject.[1] While she did not call herself a dance therapist at this time, her writings reveal a deep dedication to helping children express a variety of thoughts and feelings through dance including those that were forbidden and frightening.

Although she had extensive experience with children, and worked briefly with the retarded as well as with psychotic children at Bellevue in the 1950's, the major thrust of her dance therapy interest from the late 1950's until her death in 1982 was with an adult population which she labeled the "normal, functioning neurotic" (Evan, 1980, p.c.). One major concern which appeared first in her work with children, and later in her work with the "normal, functioning neurotic," was with the suppressive adaptive patterns of the urban individual who, surrounded by the hardness of concrete and the time pressures of a mechanized society, has, she believed, lost contact with his/her body and emotions (Evan, 1964).

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[1] This collection of essays is now reprinted and available through Barbara Melson under the title, *The Child's World: Its Relation to Dance Pedagogy.*

In the 1950's, Evan expressed concern over the fact that dance as therapy was being stressed for the psychotic individual but overlooked for the neurotic individual. Evan on the east coast and Mary Whitehouse on the west coast were the only dance therapists who stressed reaching this population. In addition, Evan and Whitehouse both stressed in-depth improvisation as the major intervening modality.

In 1956 Evan began to call her work "creative dance as therapy." In 1958, after studying at the Alfred Adler Institute of Individual Psychology and the New School for Social Research, she began to train professionals and students in her approach.

Although Evan gradually moved from a creative, educational emphasis to a psychotherapeutic emphasis, her later approach integrated much of her original teachings. This integration of creative and improvisational dance with the psychologies of Adler, Freud, Rank, and others forms the foundation of her major contributions to the theory and practice of dance therapy.

In regard to the relationship between dance therapy and creative dance, Evan stated:

> Creative dance breaks the crust. Dance Therapy leads to unravelling the knots, to diagnosis, and to active life, brain, habit change. The education of the emotions (an Adlerian term) is also possible. (Groninger, 1980, p. 17)

In her later years, as the field of dance therapy began to expand, running the gamut from "movement psychotherapy" to "psychoanalytically oriented movement therapy," Evan remained firm and clear about her commitment to dance. She did not accept the word "movement" as an accurate substitute for the word "dance" (1980, p.c.). She saw too much of dance therapy as being anti-dance and aspiring either to the verbal therapies, hence losing the inherent power of dance, or to the "mind/body" therapies which too often ignored the individual's emotions and diagnoses. Evan believed that "unlike many body/mind techniques which share some characteristics with dance therapy (breathing, posture, and vocalization, for instance), dance therapy works at getting at the causes for the client's distress in the most primal, elementary way—self-directed movement" (Groninger, 1980, p. 17). Evan integrated the verbal and the dance into a full and primary psychotherapy which she eventually called Dance/Movement/Word Therapy.

Evan opened her first studio of dance in 1934 in New York City, and in 1967 founded the Dance Therapy Center, also in New York. Later in life, due to health problems, she moved to Boulder, Colorado where she continued to teach and see clients until her death in 1982. While she lived in Colorado she frequently traveled back to New York to teach. Four proteges who carry on her work today are Bonnie Bernstein and Anne Krantz on the west coast, and Barbara Melson and Iris Rifkin-Gainer on the east coast.

Theory[2]

Evan stressed dance as the art form which utilizes the most direct and complete connection to the psyche, as differentiated from the visual arts or the use of a musical instrument.

> It is this need for psycho-physical union that Dance can so directly fulfill. . . . Its *instrument* of expression *is* the human body and its medium body movement. (1964, n.p.)

Creative Dance with Children

Evan believed that children can express in movement and metaphor what they cannot express in words:

> *I could not find in language* the *equivalent* for the *violence* I have seen children express in dance. And I would have to be a poet to describe the sadness and the delicacy. (1964, n.p.)

It was Evan's conviction that in "true creative dance, the form springs from the source. . . . It comes and goes and there is not even a momentary reminder of that which has been expressed. . . ." (1964, n.p.). Aside from these moments of break-through in dance, these intense feelings are frequently repressed. The major goal of Evan's work was to bridge the gap between psyche and soma, allowing that which became repressed or deadened to spring back to life through the resiliency of the body in the form of dance.

The challenge of the creative dance teacher as well as the therapist who utilizes creative dance was to promote mind-body unification through expressive movement while still providing instruction in the basic skills of dance. Evan reminded us that the over-emphasis on teaching dance technique to children is peculiar to our culture. She cited other cultures in which dance is indigenous to life and is transmitted as part of the whole culture. She commented on the isolation of dance in Western society from everyday life experiences and realities. This is further complicated, she felt, by urban life and the mechanized society which force us to adapt to tempos external to our own inner rhythms. In addition, she believed that urban children are too often thrown into physical and emotional isolation due to the lack of group related activities, whether in play, religion, or work.

Evan's theory was that the child, after being taught to move and sense his/her body correctly, will be better equipped to organize and explore expressive movement sequences. She stressed that ". . . children actually do not feel any dichotomy between emotional 'expression' and 'technique' unless such separation is forced upon them" (Evan, 1964, n.p.). She gave the example of a child who is asked to beat a drum; in doing so, the child's entire body intensifies with the dynamic rhythmic qualities the beat creates. In a similar fashion, a child who still

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[2] This discussion of Evan's theoretical base was derived from her very early publications on creative dance for children written in the late 1940's and 1950's, integrated with her more recent articles, ranging primarily from the late 1950's through the 1970's, and organized chronologically in her "Packet of Pieces" (1945–1978).

The unity of mind and body is expressed in the joy of these children dancing. (Photo courtesy Barbara Morgan).

experiences the integration of his mind and body, when asked to do a specific technique, permeates the action with his/her own affect. "Children will take any movement that even remotely lends itself [to dynamic expression], and transmute it through inner emotional response into a form fused with content" (Evan, 1964, n.p.).

Interestingly, Evan felt that modern dance and ballet too often geared themselves to the separation of mind and body, thus severing this dynamic quality which Evan called "the life of Dance" (1964, n.p.). Hence, the challenge of integration became the major thrust of her work.

Dance Therapy with the Neurotic Urban Adult

In her work with urban adults, Evan frequently encountered complaints and excuses concerning issues of fatigue. She interpreted these issues as manifestations of inner drives toward repression, fear, and dependency, causing clients to resist using their full physical potential.

Evan cautioned the therapist against over-identifying with these repressive drives which, she believed, are in constant struggle with and can be overcome by the opposing drives toward self-expression. Frequently, all the client needs is a push in the direction of feeling and experiencing the self (Evan, 1945–78, n.p.).

In accordance with Adlerian psychology, Evan believed that repressed agression and anger are the major maladies of the neurotic. Because the neurotic's anger is repressed, so is his/her assertiveness and commitment to growing up. This is reflected clearly in the body musculature. "With action repressed, the energy is diverted to different kinds of tension: rigidity at one extreme, apathy at the other" (1945–1978, n.p.).

According to Evan, the hands, face, and voice are often the last areas to be released. She spoke of the tendency for the neurotic to try to mask his/her feelings by constricting the facial muscles which otherwise would make his/her emotions visible. Regarding the voice, which she believed was the hardest to release, she stated, "Self-produced sounds seem to wake up the whole person in an immediate kind of way" (Groninger, 1980, p. 17). Through sound, the emotions are heard as well as seen. Evan reminded us that suppression in childhood is usually in sound more than in movement, that is, children are to be seen but not heard.

Another common problem of the neurotic is the exertion wasted in an attempt to maintain self-defeating attitudes (Evan, 1945–78). If the body is trained for years in non-expression, the need to express may eventually become lost. In severe cases, the resiliency of the muscles can be totally destroyed. "Body and spirit split and begin to atrophy; ego power shrinks to low self-esteem with an ineptness for both anger and love" (Evan, 1945–78, n.p.).

Evan's goal was to re-educate individuals to the natural unification and identification with organic bodily responses and needs which, she believed, existed prior to the repressive influences of family and society. This does not mean training individuals to be impulsive, but rather to use the expressive and creative aspects of the dance form as a vehicle for dramatic enactments of thoughts and feelings that might otherwise be repressed, destroyed, or turned inward against the self.

Inherent in Evan's work was her stress on the use of the ego function of regression in the service of the ego.[3] Dance was viewed as an ego function, that is, directed and spontaneous use of rhythm, exertion, and form, which can help individuals to experience and express repressed traumas and other forbidden and frightening thoughts and feelings. In short, for Evan, dance was a language very similar to words. But unlike words, dance represented a more direct communication and language of the self.

Finally, Evan worked with the whole person. That is, she emphasized the person in his/her world. She did not believe, as the traditional psychoanalysts did, that insight and the awareness of unconscious material alone constituted the goals of treatment. If an individual, after completion of psychotherapy, was not better equipped to cope with his/her life, both intrapersonally and interpersonally, Evan believed that the treatment was not successful (B. Melson, 1987, p.c.).

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[3] While the terminology "regression in the service of the ego" was not actually used by Evan, it serves here to describe the movement process which Evan catalyzed.

Methodology[4]

Overall Structure

Evan practiced for approximately 25 years both individually and in groups. Her methodology is composed of four major modes of intervention: the warm-up, "Evan's system of functional technique," improvisation/enactment, and verbalization of thoughts and feelings. The order of these basic intervention styles varied, and they were not all present in each session. The following discussion concentrates on the first three classifications, the role they play therapeutically, and their interrelationship.

Physical Warm-up

The warm-up is a process of releasing superficial/excess tension, helping the individual to achieve a state that mediates between relaxation and tension, and thus paves the way for receptivity to bodily feelings, emotions, and possible expressive actions. It could also be used to move people out of apathetic and physically depressed states.

The warm-up is aimed at bringing people into contact with the reality of their psychophysical selves. Evan stressed that with clients using movement for the first time in an expressive manner, the warm-up is especially important. Its function is that of preparing the body both for corrective body work, that is, functional technique, and for the expression of thoughts and feelings often evoked later in the session through Evan's thematic improvisational work. It is important to stress that the warm-up was not designed to dissipate emotional conflict and its resulting tension, but to reduce the individual's excess tension which Evan believed served to camouflage deeper problems.

Early in her career, Evan encouraged a lot of free swinging of the body in all directions for individuals who were very tense. She believed that the swing was usually the easiest, most accessible movement for everyone, providing a feeling of freedom while at the same time offering security in its rhythmicity. Later, this emphasis on the swing moved to a more general emphasis on total joint mobilization through many different kinds of movements, for example, skipping, running, jumping, rotating, and shaking out body parts. (Rifkin-Gainer, 1986, p. 6). She often used drum beats which steadily increased in tempo so that individuals would be led into faster and freer motions. She worked for a sense of ease and abandon in the body with the goal of eventually helping the individual to give his/her body to the spontaneous creation of expressive form in improvisation.

The warm-ups were sometimes with music and other times without. Evan often asked if anyone would like music and, if so, what kind. Often she let members do their own actions alone to warm-up and loosen the body, and other times, she had the group make a circle and each group member would suggest or begin a warm-up action which the other members then picked up on. From here group members could take turns at leadership.

Before completing the warm-up Evan might ask how the group felt and whether anyone needed more work on a particular part of the body. If someone did, more exercises were done. At times, Evan helped members release difficult tension areas by exaggerating the

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[4] Most of the information in this section has been taken from the author's group dance therapy training with Evan in the early 1970's. This has been augmented by Evan's own writings, and by personal communications with Evan and Rifkin-Gainer in 1980 and with Rifkin-Gainer, Melson, and Krantz in 1987.

muscular rigidity and then releasing it. One loosening exercise was the isolation of body segments. For example, to a slow and then increasing drum beat, she might first have clients just release shoulders and then hips. Because her goal was always integration of the whole body, Evan would have clients do integration movements (e.g., large rhythmic total body movements) not only after isolations but before as well, believing that most people were already tense and over-segmented.

It is important to note that there were times when Evan believed a warm-up was contraindicated. The warm-up, if used incorrectly or indiscriminately, could serve to prematurely dissipate important psycho-physical energy which the client needs in order to mobilize him/herself in the direction of working through emotional conflicts and trauma (Melson, Rifkin-Gainer, 1987, p.c.). An experienced dance therapist can judge when the client arrives whether he/she is ready to move directly into pressing emotional material, or if a warm-up is required first and what kind of warm-up is indicated.

Except for the cases in which the warm-up was contraindicated, Evan stressed a thorough warm-up. It was considered an essential part of the process, without which the body might not be able to fully process the unconscious material that frequently surfaced during the improvisational phase of the sessions.

The Evan System of Functional Technique[5]

The Evan system of functional technique was described by Evan in 1980 as:

> corrective exercise designed to retrain muscles to move in relation to nature's design in a rhythmic expansion and contraction. . . . Spontaneity and resilience . . . are enhanced by the individual's discovery of his own rhythm and tempo. (Groninger, 1980, p. 17)

Evan's studies with Bird Larson laid the groundwork for her system of functional technique (Rifkin-Gainer, et al., 1984, p. 14). It is a system that rehabilitates and educates the body in an anatomically sound way. Functional technique includes postural work, coordination, placement of body parts, and rhythmicity. This style of work is individualized, that is, it varies, adapting to the individual's unique anatomical needs. In Evan's words, functional technique ". . . respects nature's plan of the body in action. . . . Changing the body tonus from destructive tension to resilience is vital" (Rifkin-Gainer, et al., 1984, p. 14).

Evan stressed the strengthening and alignment of the spine as the foundation of all action. She also commented on human verticality as our unique distinction from other species, believing that this distinction carries with it an emotional responsibility as well as the physical task of supporting and balancing the body. Evan's concern with the spine centered around her belief that the functioning of the spine determines the overall ability to use the body as an "Instrument of Dance" (1964, n.p.), and therefore as an instrument of self-expression.

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[5] In the published material which Evan has written, there is little that describes in detail the Evan system of functional technique. However, in "Life is Movement, the Blanche Evan Dance Foundation" Evan has more than 100 pages of material on this technique. From her early articles (1964), we know that she was influenced by Mensendieck's functional exercises; Todd, *The Thinking Body* (1937); and Scott, *Analysis of Human Motion* (1963). The ideas presented in this section are abstracted from these articles and from the author's training with Evan in the early 1970s.

She further believed that limitations in the overall strength and flexibility of the spine lead to insecurity and fear.

Some of the goals of functional technique are:

1. to rehabilitate the body.
2. to give the individual permission to take up and use space in a variety of ways that he/she would not feel free to try alone.
3. to give the body the strength and range of motion that it will need for emotional expression; to provide the physical base upon which one can build one's own unique expressive movement vocabulary.
4. to help the individual feel more secure about physical self-expression. This is achieved when the individual feels an increase in control over his/her body.
5. to bring the individual into contact with parts of the body that were previously out of his/her conscious awareness.
6. to integrate functional contraction with functional release for the purpose of achieving more efficient and meaningful movement expression.

In regard to teaching functional technique, Evan stated:

> Technique need not be treated as an amputated limb of Dance. It is rather one of its functional organs. It can be presented so that its pursuit does not become a block to creative spontaneity. . . . The work in CREATIVE DANCE need not negate form. Ideally it should seek a new form that is the result of a union of unmannered technique with the creative use of [personal] content. (1964, n.p.)

Improvisation/Enactment[6]

Improvisation is defined by Evan as:

> . . . the spontaneous creation of form. Form and content ideally are one. Dance improvisation is the complete welding of yourself, as you are at the moment, with your theme, in terms of Dance. The beginning is the moment of merging; developing proceeds, climax is achieved, and there is only one right moment for the end, when the theme, as it relates to you, has spun out its course. (1964, n.p.)

Here, Evan was referring to the inner sense of completion and what can be called the "internal clock," which unwinds body movement in the spontaneous creation of form with an inherent sense of the beginning, the middle, and the end. Evan placed equal stress on the physiological and psychological. She emphasized ". . . the need of the human being to experience the physical equivalent of the psyche in the body through action" (1964, n.p.).

Evan's improvisational work can be classified into three approaches: a) projective techniques; b) sensitization to and mobilization of potential body action; and c) in-depth and/or complex improvisation. The first two categories represent what can be called emotional warm-ups. They prepare the individual, through simple improvisational tasks, for the third category, that is, more in-depth and/or complex improvisational work. The latter forms the major content of the dance therapy session, and at times can be likened to the free association process in psychoanalysis, but enacted on a motor level—psychomotor association.[7]

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[6] The following discussion comes from several sources, including Evan's article "I am the Sun" (1964), notes from Evan's "Intensive Dance Therapy Training" course which the author took in the early 1970s, as well as Evan's write-up of the case of Pamela and a paper she published in 1970 in the *Journal of Pastoral Counseling*. The latter two are reprinted in her booklet entitled *Packet of Pieces* (1945–78).

Projective Technique

The use of the projective technique was a cornerstone of Evan's work, brought directly from her background in creative dance. Evan believed that adults could often benefit from being an animal, color, or texture in movement. Evan used the projective technique both for self-expression and diagnostic purposes.

In utilizing creative themes, she made a choice as to how specific or general to be. This choice was determined by the client's needs. For example, in using themes from nature, she could either suggest categorical themes, such as "be an animal" or "be an inanimate aspect of nature," or she could narrow the field slightly by asking the client to choose a four-legged animal, or a reptile, or a bird. Similarly, she could say, "choose a tree which most represents how you feel today." This latter example could also be done with water, wind, sky, and so on. For example, if the client was asked to be water in any form, he/she would have many choices: ice, vapor, the ocean, a brook, shower, or storm. In this way, the client would fill in the blank with an image which was inevitably a projection of one part of his/her own feeling state. That is, the client might feel turbulent like a storm, rough like the seas, or gentle like a pond.

While exploring, for example, the turbulence of a storm, the individual might become aware of the feeling of anger which, after a certain amount of unfocused release, might pave the way for a more structured release. That is, the anger might become focused, for example, at a specific person or event in the individual's life.

The projective technique in this case might be called an emotional warm-up or barometer in that it attunes the individual to a specific feeling which presses to express itself physically. After some discussion, the insights gained through Evan's observations and the client's self-reflection could be directed into a more complex improvisational structure where the client would focus his/her attention on the surfacing imagery or conflict and explore it in depth through body movement.[8]

Another style of the projective technique used by Evan was eliciting the fantasies of clients and, if not contraindicated, helping them to enact these fantasies in body movement. This could be a fantasy of their ideal self, of a place they would like to be, or of something they would like to do or say to someone.

Finally, Evan used words, phrases, and sentences to facilitate projection through body movement. She might suggest as a warm-up to an in-depth improvisation that her client move spontaneously to the images that arise from several words which Evan would toss out quickly and successively. These would be aimed at freeing the individual from inhibition and

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[7] Many of the terms used here were selected in an attempt to describe and organize Evan's work. Evan herself did not use them in her teachings.

[8] This progression from form to content, ushered in through projective technique, is explored further in Chapter 16, "Psychodramatic Movement Therapy."

Children's faces and voices express their unity with nature. (Photo courtesy Barbara Morgan.)

over-intellectualization, replacing these with spontaneity of associations and their corresponding movement responses. Evan would also toss out incomplete sentences, encouraging clients to complete them in movement, for example, "My body can ______", "I'm going to ______", "I feel ______", or "I want to be ______".

After such an exercise, discussion might take place on what occurred in the emotional warm-up process. From this, more intense themes may emerge which Evan and the client would then structure into more intense and complex movement explorations.

Evan eventually moved away from the technique of offering imagery to her clients, and moved toward utilizing images that emerged spontaneously from the therapeutic process. In the latter part of her career she noted certain risks in providing images to clients; she felt that a therapist could never know what the clients's associations would be to externally prompted imagery (Rifkin-Gainer, 1980; Melson, 1987). This move away from externally prompted themes was reflective of Evan's gradual move away from her creative dance background and toward more in depth psychotherapy through dance.

Sensitization to and Mobilization of Potential Body Action

Evan also used projective techniques in relationship to expanding the client's movement repertoire. The goal of sensitization to and mobilization of potential body action was to bring potential movement into actual movement through stimulating the elements of dance (i.e., time, space, intensity, rhythmic flow, content). This was accomplished by providing specific images, stimuli, and movement directives. Evan might play percussive instruments, varying the intensity, the rhythm, and the instrument and thus providing varied stimuli to the body, that is, fast/slow, staccoto/legato, loud/soft, upbeat/downbeat, and so on.

Another way to stimulate dynamic movement as well as psychic and somatic projection is through the use of props. Props usually demand action and specific qualities of movement. For example, a flowing scarf, though varied in its possibilities, would generally encourage different movements than a hoop or a ball. Also, scarves can vary greatly in their texture, weight and in the tactile sensations they stimulate, helping to determine the quality of movement for which they are most suited.

Words, especially verbs or adjectives, are also provocative in terms of exploring varieties of movement possibilities. For example, words used in opposition are especially evocative and meaningful; gather/scatter, open/close, strong/soft, round/angular, sunny/rainy, clear/foggy, morning/night, choppy/smooth, and so on.

In these examples of verbal facilitation through contrasting movement themes, images have been pulled from several categories, such as time of day, tempo, texture, shape, weather, and so on. Some of these contrasting images describe specifically the type of movement the dance therapist believes the individual needs to develop (e.g., round/angular). When the dance therapist uses or encourages the client to choose physically directive words like round and angular, part of the projective aspect of the exercise is omitted and replaced with a "prescribed" movement pattern. The individual is directly encouraged to use the muscles the dance therapist believes he/she needs to develop for increased expressivity. On the other hand, words such as morning/night are subject to greater personal interpretation; they leave larger blanks for the individual to fill in with his/her own free (movement) associations. The latter is actually a projective technique which has the additional effect of broadening the movement repertoire.

Evan emphasized the importance of knowing why you are asking an individual to do a specific movement exploration. Are you looking (as in the latter example) for associations to the movement so as to provoke emotional content for future complex improvisations? Or, are you trying (as in the former example) to build specific muscular strength, awareness, and flexibility so that the body is ready for the unconscious thoughts and feelings that surface during these explorations? In either case, the individual is warming up to more intense and personal movement work.

Another technique for helping the individual to learn, experience, and employ his/her full movement potential is to use the elements of dance directly, exploring the extremes and gradations of tempo, weight, and space using action words which guide the individual. For example, if an individual is working on a theme in a simple improvisation, Evan might make movement suggestions to help the individual explore more fully certain movement qualities. She might offer movement suggestions such as "Add weight," "Can you move faster?", or "Can you add rhythm to your movement?" This would be more applicable to brief improvisations than to full complex improvisations, during which Evan usually just observed the process until individual brought the improvisation to closure.

To encourage new movement qualities in interaction, Evan would have individuals work in dyads with each taking turns in contrasting roles. This could take place through specific roles, for example, one person becoming a tree while the other is the wind. Again, this would encourage contrasting movement dynamics with room for projection of emotionally meaningful content, therefore acting as a warm-up for future in-depth work.

Finally, concrete images can broaden and expand the movement repertoire. Evan emphasized the importance of concrete and simple directions for beginners who are not accustomed to using their bodies to express feelings and ideas. Giving them a complicated or abstract direction too soon could encourage an over-intellectualization of the movement process and lose the emotional intent. As with the projective techniques, the possibilities for the use of concrete images are practically unlimited. Examples include pushing a wall, kicking a ball, or wringing a towel. Any of these could be used for physical release, expanding the movement repertoire and stimulating projective material.

In summary, projective techniques and sensitization to and mobilization of potential body action at times overlap in function; they simply represent a different emphasis. The former emphasizes the surfacing of unconscious material, while the latter emphasizes broadening the movement repertoire. Because the muscles are the holder of emotions, any qualitative work on broadening the movement repertoire inevitably works to release the concomitant psychic associations, and vice versa: any work which loosens unconscious associations broadens expressive movement. In addition, both approaches facilitate the emotional warm-up through simple improvisational structures. These structures pave the way for the third aspect of Evan's work.

In-depth and/or Complex Improvisation

Evan was prepared to structure an in-depth movement problem or theme out of any part of the dance therapy session. Movement directives evolved out of the physical warm-up, functional technique, the emotional warm-up (i.e., the projective techniques and mobilization of potential body movement), and/or the client's verbalizations. Evan frequently structured movement suggestions around thoughts and feelings the client had about his/her own body, including fears, fantasies, illusions, and/or somatic identifications of oneself with others.

In the following case study of Pamela (1945–78) Evan demonstrates the use of complex in-depth dance improvisation emphasizing dramatic enactment of past traumas.

In her work with Pamela, Evan began with the "movement interview," using specific exercises for the joint purpose of getting to know the physical strengths, weaknesses, and potential of the client as well as exploring how Pamela felt about and perceived her body. As Evan listened to and watched Pamela, she stayed alert for possible movement themes which Pamela could later focus on for improvisational enactments.

In her initial interviews, Pamela expressed many insecurities and doubts about her physical appearance. Evan decided to explore this further by asking Pamela to shut her eyes and

Blanche Evan

describe her own body. Pamela gave a thorough description but said nothing of her arms and hands. When Evan questioned her about this, she replied that she felt the skin on her hands was like alligator skin. Evan did not pursue this further at this time. In regard to dancing, Pamela stated that she hated lying on the floor when dancing. She described her mother's body and walk, though it is not clear if Evan requested this information or if Pamela simply offered it. In her early discussion with Pamela, Pamela's preoccupation with her family's judgments of her body emerged. Evan believed that dance therapy could play an especially important role with individuals who have experienced severe family criticism and rejection of the parts of the body. Evan took note of Pamela's verbalizations in regard to family criticism and rejection as well as Pamela's initial omission of her hands and arms in her body description.

After gathering information, Evan asked Pamela to obvserve herself walking. Evan was surprised at the lack of reflection Pamela had concerning her own walk as compared to her detailed response to her body image. The only thing Pamela was very aware of was that she hated to stroll or walk slowly, and that she would always feel an urgency to pass any slow walkers who were walking ahead of her. Next, Evan asked Pamela to run. Pamela said it was difficult to run without an image of why she was running. She also complained of a general lack of breath and endurance except when she had the image of running after someone, then she was able to run without stopping for an hour. Along these same lines, Pamela also mentioned her extreme endurance when she was angry. Pamela was an actress and so was aware of these peculiar variations in her patterns of endurance.

Further movement observation of Pamela revealed that when she ran, her feet, upon landing, did not make full impact with the ground. Evan spoke to Pamela about this and Pamela responded that she never put her full foot down because she disliked her feet, believing she was flat-footed and hence had ugly feet. Evan quickly intervened in this on a physical level, providing her with correct placement of her feet on the ground which quickly corrected this problem.

In these early sessions, Evan asked Pamela to do several other exercises. In each she noted Pamela's total use of her body. Some exercises went easily with little need for discussion. For example, Evan asked Pamela to lie down and place a drum on her adbomen to see what Pamela's breath capacity was, and this Pamela did easily.

One theme which continually repeated itself in Evan's early observation was Pamela's frustration with people walking slowly in front of her. Because of the repetitiveness of this theme, Evan decided to pursue it. Hence she asked Pamela for her associations to this image. In response, Pamela spoke of her mother who had two tendencies: one was to be very messy and take up a lot of space in the house and the other was to move slowly and in this way make Pamela late for appointments.

Evan, keenly aware of the importance of tempo and its effect on the body and emotional adjustment, explored how slowness affected Pamela in her own behavior. Pamela was able to recall periods of doing nothing when she had had plans to get things done. Also, when Pamela tried to lose weight she frequently accompanied periods of not eating with not moving. Thus, while Pamela expressed resentment of her mother's patterns of slowness, her unhealthy attachment to her mother was evident in her own struggle with getting things done, her lack of endurance, her periods of doing nothing and coming late to therapy (a rare occurrence). In this case Evan's major goal was that of helping Pamela to separate her own body image and behavior from that of her mother. The conflict between Pamela and her mother, centering around issues of timing, can be viewed from a non-verbal perspective in relation to Evan's definition of dance as it pertains to dance therapy: "space, time, body movement dynamics and content welded in unity" (1945–1978, n.p.). Thus, Evan's goal was to unweld space, time, body movement dynamics, and content for the purpose of unraveling this tight unit of behavior which controlled Pamela on an unconscious level. The following describes the course of Evan's intervention with Pamela to help in achieving this goal of separation from the destructive relationship Pamela had with her mother.

After collecting pertinent information through exercises and discussion, Evan made her first major intervention. She asked Pamela to choose between two movement themes which Evan posed. The first was to "assume the physical characteristics in movement of anyone who at any time had rejected her on the basis of bodily characteristics" (1945–1978, n.p.). The second was to "assume the physical characteristics in movement of her mother." Pamela chose the latter, though with initial resistance. In doing this Pamela began by becoming her mother as she perceived her first in the present and then from the past. Evan explained to Pamela that she was "trying to take things out of her mind where they had been brewing and to begin to let them out through the channel of the body" (1945–1978, n.p.).

In Pamela's enactment of her mother from past memories she spontaneously dramatized three episodes of physical abuse. The enactment was composed of a rush of words, tears, and movements. She suddenly became absorbed in the expressions of grief, anger, desperation, and confusion as she switched in movement back and forth between the role of her mother violently assaulting her and her own frightened, angry, and bewildered reactions, the reactions of a small child.

In the next session Pamela returned saying she felt straighter in her posture and more able to tolerate and enjoy moving slowly. At this time Evan emphasized that her goal was for Pamela to reclaim a positive identification with her own body and establish her own standards for personal evaluation, differentiated from the rejection and admonition of her mother and relatives. Evan took this opportunity to go over exercises they had done so far and to encourage Pamela to do these exercises every day. Evan is unique in her stress on the integration of exercises which she would ask the client to do on his/her own as an integral part of her work and in conjunction with dramatic enactments and improvisation. It appears that Evan made the decision to emphasize rehabilitation of the body at this time when Pamela was feeling healthy and strong as a way to integrate and reinforce this good feeling in the form of healthy functioning of the body. In this way the good feeling was solidified through its physical concomitant, good form.

Evan frequently integrated assignments outside of the therapy session with work in the session. Because of Pamela's feelings about her hands, Evan had her find pictures in artwork of hands. Her goal was to help Pamela find hands she responded positively to and to help her use these pictures to explore the conflicting feelings she had about her hands. Evan also provided her with exercises for her hands, but Pamela had an ambivalent response to these. When Evan saw that this work brought very disturbing memories back to Pamela about her mother and also about having been pushed into dance classes as a child, Evan decided to temporarily suspend the exercise aspect of her work with Pamela.

During this period of intense ambivalence and blocking around the subject of hands, Evan stressed expressive movement activities employing dramatic enactments and other forms of body image work.

The following is an example of Evan's use of a dream to encourage exploration and insight through enactment and work on body image. Pamela had spoken of having several nightmares and waking up with partial paralysis. As Pamela described one of these dreams she was very agitated. Several sessions previously, Pamela had verbalized her problems quite persistently. Though Evan allowed this, realizing Pamela's desperate need to talk, Evan knew Pamela needed to return to movement in order to explore the subjective reality of the dream on a muscular level. When Evan saw Pamela becoming more agitated while discussing her dream, she finally interrupted, saying "Stop talking and move" (1945–1978, n.p.). Evan felt that with this extra push for the nonverbal expression, Pamela would be much more able to probe her innermost associations, thoughts and feelings. This later became a theme in Evan's training of dance therapists, that is, an emphasis on bringing the expression back to its somatic reality or source in the body as opposed to encouraging verbal exploration.

Pamela complied with Evan's instruction and began to dance her dream. The movements ushered on the cathartic release of tears along with more movement as well as verbalization, but this time with deeper commitment and affect. In the dream enactment, Pamela externalized physically and verbally the sensation of women pursuing her aggressively and wanting something from her. In the dream Pamela is very small. She is trying to hide but they come after her. She told Evan she wanted to be under the ground. When Evan threw her a blanket, she crouched under it and expressed ambivalence about touching her own body.

When Pamela finished the dream enactment and verbalization, Evan asked her to look at her hands and describe what she saw. She then had her do the same with her face. Her response again indicated a negative and disturbed body image.

Evan then asked her when she remembered first not liking her body and she recalled it was when she was in a crib and ill. She recalled her arms being clamped down and not being able to breathe. Evan then asked Pamela to look at her hands again and in association to this she became aware of a sexual identity conflict, feeling neither male nor female but rather like an "oddity." Through her enactment of the dream along with the body image work (i.e., having Pamela talk about what she sees in different parts of her body) Pamela became aware of seeing her mother and grandmother as masculine, and herself as very small in relation to them, as exemplified in her dreams.

The theme of being small, like the theme of moving slowly, returned regularly. Because of the persistence of this theme, Evan decided to explore Pamela's associations to "smallness." Evan approached this by telling Pamela she was going to give her a choice of three movement themes on which Pamela would be asked to focus her movement work. Evan suggested that she begin with the theme "being little," but gave Pamela the option of beginning with one of the other themes instead.

Pamela agreed to this one without hearing the others. When she began the movement work she crouched low to the ground. Evan insisted that she crouch even lower down, becoming as little as possible. In doing this Pamela became aware of a memory of falling in the bathroom while being bathed as a very small child and being laughed at by her mother and grandmother. She also recalled that this same feeling of smallness stayed with her in school as a child.

This approach appears to be that of exaggerating and hence externalizing the physical representation of the emotional state of the client for the purpose of helping him/her to experience fully his/her emotions. Through encouraging the physical expression of the regression the individual makes contact with early memories, as Pamela did (the fall in the bathroom). From this point Evan and the client could probe together this new material previously stored in the musculature, and out of the individual's consciousness. In this way Evan sought to take knowledge and insight out of the intellectualized, non-emotional state and into the reality of the individual's innermost emotions. Evan stressed regression (via body movement) in the service of the ego for the more total integration of the self.

Summary

Blanche Evan was a pioneer in the use of dance as therapy with the functioning urban adult, who she perhaps humorously called the "normal neurotic." Her special concern was with the plight of the urban adult, who, under extraordinary external and internal pressure due partially to his/her alienation from the rhythms of nature, has lost contact with his/her inner emotional and physical self and thereby is less able to cope with his/her world.

Evan believed that dance is man's natural tool for reuniting mind and body and that dance therapy is uniquely suited to re-educate neurotic urban adults to their natural expressive body rhythms, rendering them less vulnerable to external pressure. Evan's incorporation of creative dance improvisation (simple improvisation) with complex in-depth improvisation, complemented by her system of functional technique and her understanding of psychology, form the foundation of Evan's dance therapy methodology.

3

Liljan Espenak

Liljan Espenak was born in Bergen Norway. In the late 1920's she studied movement and dance in Dresden, Germany with Mary Wigman at the Wigman Conservatory, and toured with her as a member of her dance company for several years. Espenak received a diploma from the Wigman Conservatory and was a dance teacher at the Wigman School until 1934. She also attended the Berlin University and majored in physiology at the Hochschule fur Leibesubungen. During that time she had her own school of movement, accredited by the Prussian Board of Education. In addition to her education in dance and physiology, Espenak studied eurythmics with Dalcroze, and the gymnastic techniques of Mensendieck and Medau.

Fleeing Hitler's Germany, Espenak went first to England and then to the United States. In the 1940's, she taught dance in New York City at the YWCA and at the Wright Oral School for the Deaf. In the 1950's, she studied psychotherapy for three years at the Alfred Adler Institute and actively integrated her own knowledge of psychology with her already well-developed knowledge of the expressive, social, and personal nature of dance. In 1961, Espenak became the Director of the Division of Creative Therapies, Institute for Mental Retardation, New York Medical College. Subsequently, she became Assistant Professor and Coordinator of a postgraduate course in psychomotor and dance therapy at New York Medical College's Mental Retardation Institute and a dance therapist at the Alfred Adler Mental Hygiene Clinic (Espenak, 1980, p.c.).

Espenak is responsible for influencing many second generation dance therapists through her early course in dance therapy given at New York Medical College (1961–1981), the first of its kind offered on a post-graduate level. She is also well known for her work with the retarded and for her work in private practice.

Like all of the early pioneers, Espenak did not consciously decide to become a dance therapist. Rather, her career moved naturally from modern dancing to teaching creative dance to dance therapy. Her original goal was to be an "ideal teacher," but, she says, ". . .when groups became emotional later on. . .the process became dance therapy and I, a dance therapist" (1981, p. 10). Her first contact with dance therapy as a professional discipline was the early course she took with Marian Chace at the Turtle Bay Music School.

Espenak, like many others in the field, owes a great deal to Wigman and Laban. She believes that the combined contributions of Laban's theoretical and descriptive approach to dance and Wigman's creative improvisational approach formed the foundation upon which dance therapy is structured.

> Unintentionally, this combination gave dance therapy its two most important facets, the free improvisation by the creative emotional self, and the organizational structure needed to harness and project the emotions. (Espenak, 1979, p. 72).

Espenak's work combines the psychoanalytic theory of Adler with the mind/body theories of Lowen (1967, 1973) within the context of what she calls "psychomotor therapy." She defines psychomotor therapy as an "extension of dance therapy through application of diagnostic tools for treatment on the medical model of observation, diagnosis, treatment" (Espenak, 1985, p.c.) This integration of Adlerian concepts into a psychomotor modality helps to strengthen and broaden the formulations on which dance therapists base their work.

Espenak has written several excellent papers and a book entitled *Dance Therapy: Theory and Application* (1981), in which her ideas are clearly outlined and discussed. She also developed a set of movement diagnostic tests, and in the 1960's began her training of students at New York Medical College in psychomotor therapy.

Theory

Our discussion of Espenak's theoretical base focuses on her integration of Adlerian concepts into the discipline of dance therapy. Espenak notes that Adler began his professional career as a neurologist in Vienna, and she believes that his "holistic" (mind/body) approach to psychology was influenced by his early training (1979).

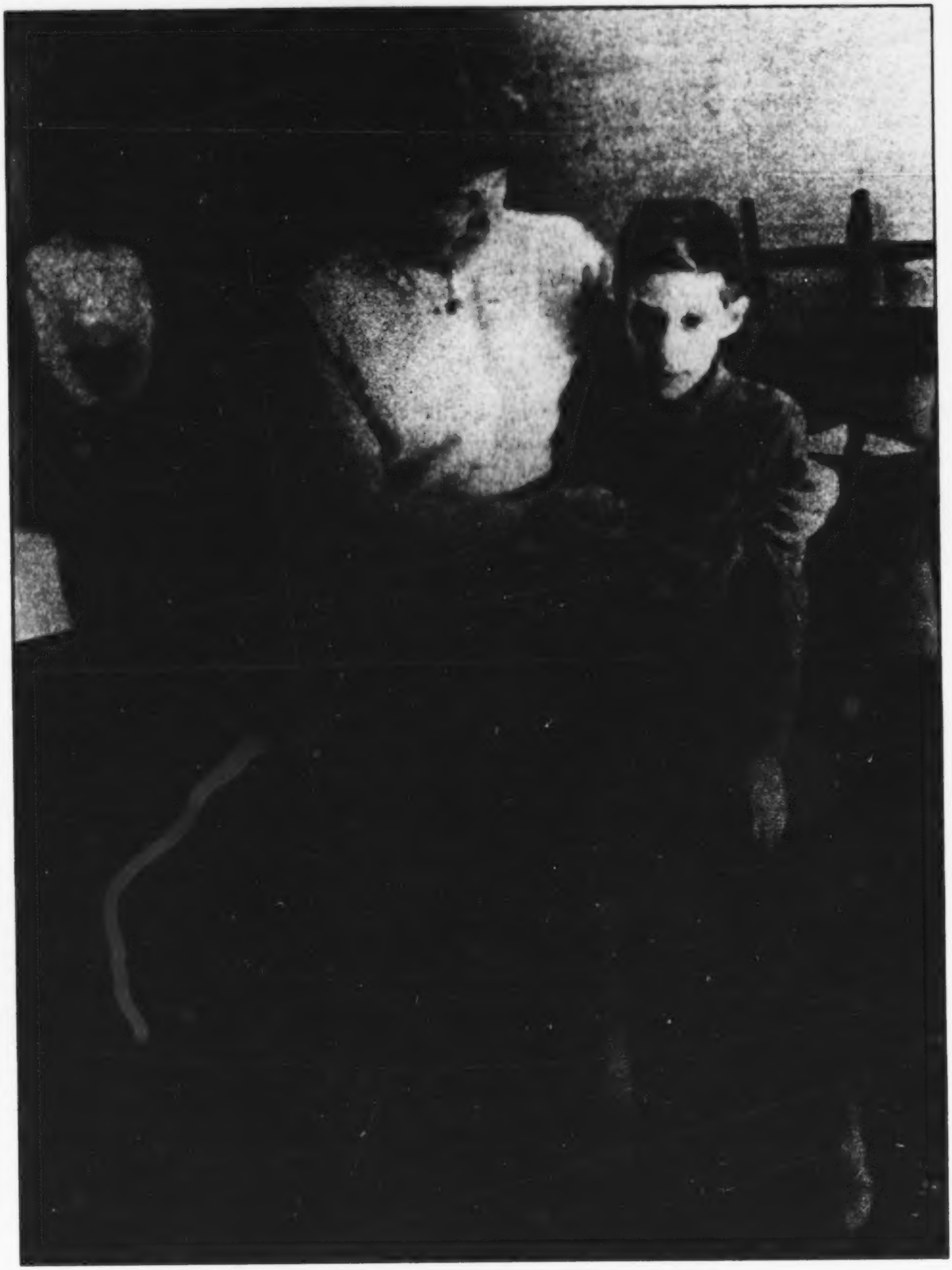
Espenak stresses three major Adlerian concepts as being integral to dance therapy: the aggression drive, inferiority feelings, and social feelings (i.e., the need to be accepted by the community). Espenak also refers to a fourth classification of Adler's, that is, life style and first memory, which will be discussed in the following section on Espenak's methodology.

Adler's acknowledgement of the aggression drive and his belief that it is as important and significant in development as the sexual drive (libido) were revolutionary. Freud, at first, negated Adler's emphasis on the aggression drive and sibling rivalry, but toward the end of his life, Freud stated openly his acceptance of Adler's major contribution and acknowledged his own short-sightedness in this area (Ansbacher, 1956).

Espenak believes that the aggression drive is a natural and necessary aspect of life and that if repressed, the dynamic force and life-giving source in the personality would also be repressed (Ansbacher, 1956; Espenak, 1979).

> When aggression drive is seen as original life force, life energy, unconscious desire to live, it becomes an expression of health and natural dynamics for which we must be deeply grateful, if illness or early repressions have not extinguished it. Dealing with suppressed aggression drive through dealing with anger is a frequent and important goal of psychomotor therapy. (Espenak, p. 76)

In her discussion of the aggression drive, Espenak also frequently refers to the Adlerian concept of childhood feelings of inferiority. Espenak integrates both Adler's aggression and inferiority theories with Freud's libidinal concept of the pleasure principle.



Liljan Espenak working with patient at New York Medical College.

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> Without the biological Aggression drive and the pleasure principle, the inferiority feelings would not result in striving for superiority, but be accepted as unchangeable . . . Inferiority feelings then remain together with the developing recognition of the powerful surroundings, and acceptance of their interaction. The aggressive drive, however, will lead to nonacceptance of this position and result in striving for superiority as a means of obtaining the pleasure principle. (1979, p. 76)

In other words, the human instinct toward aggression combines with the child's awareness of his/her physically and emotionally inferior role in society. These two aspects of the individual's existence together push the individual on to find ways to master both his/her environment and his/her self.

Espenak believes that working directly on the body, developing physical strength, grounding, and an expressive movement vocabulary can help to counteract the original feelings of inferiority and dependency. For example, the acts of stretching, pulling, pushing, leaping, running, and skipping all engender feelings of taking charge, defying gravity, making one's self larger and better, and generally enhancing feelings of well being. Moreover, as the movement sequences in which the individual engages become more intricate, requiring greater control and mastering, a natural sense of one's potential ability to learn and conquer combats the original feeling of inferiority (Espenak, 1979).

Espenak's theoretical framework also incorporates Adler's emphasis on the importance of developing social feeling and cooperation. He believed that if the individual's abilities in this area were either unused because of actual physical isolation of some kind or repressed due to personal rejection or deprivation in early childhood, a sense of stability and effectiveness regarding relations and rapport with the broader community would be unattainable. This would then encourage feelings of insecurity, anger, and fear (Adler, 1927; Espenak, 1979).

Espenak incorporates Adler's stress on social rapport in connection with the use of dance therapy in groups. She notes that Adler began using verbal groups for their therapuetic value with children in Europe in the early 1900's. It is Espenak's belief that "dancing together, and interrelating singly with a group, is an ideal form for discovering and developing social feeling" (Espenak, 1979, p. 77). In regard to specific theory concerning the therapeutic value of group dance therapy, she refers to the values familiar to most forms of group therapy, such as support, rapport, validation, breaking through isolation, and receiving group feedback.

Espenak often uses group work as the second phase of a patient's treatment program. The first phase, individual work with the patient, prepares him/her for the development of social feeling within a group dance therapy approach.

Methodology

In Espenak's work she integrates the formulations already mentioned with her knowledge of the work of Alexander Lowen. In this respect her work, which began in the late 1950's and early 1960's, very much reflects the spirit of the times as well as a similarity with other contemporary trends within the dance therapy discipline.

Espenak's approach to the use of movement in psychotherapy puts a great deal of emphasis on what she has called laying "the groundwork for movement" (1979, p. 80). When the inhibitions and/or repressions of the individual do not allow for free movement of certain parts of the body or for spontaneous movement expression, Espenak facilitates the movement process through structuring movement sequences designed to strengthen certain parts of the body, loosen and relax constricted body parts, and/or help the patient to experience body parts previously out of the patient's conscious awareness. This approach overlaps in some aspects with Lowen's bioenergetic work.

In Espenak's (1972) paper, "Body-Dynamics and Dance in Individual Psychotherapy," she describes three cases in which she uses the introduction of certain movement sequences for the purpose of building an expressive movement vocabulary and a tolerance for the expression of specific emotions. Espenak used her own set of movement diagnostic tests as a guide to identifying the strengths and weaknesses in the patient's psycho-physical integration. This set of tests was administered at the start of treatment and at three month intervals thereafter. She then formed a treatment plan based on her diagnostic findings.

One of these case studies (1972) provides a good example of her clinical practice. This is the case of a patient, "O.," referred by a psychiatrist because of his disassociation from his body. Because of O.'s lack of physical awareness and immobility in certain parts of his body, he was unsuccessful in his desire to succeed in theatre.

> Upon testing, O. indicated numbness in the sacrum and at the base of the neck. His legs seemed to work independently of his torso and he carried his shoulders and head as a separate unit. The chest was immobile and sunken; the head forward as if in hopelessness. This demonstrates a lack of coordination in the body between the upper and lower parts, due to the inactivity and numbness of the sacrum. The first step in therapy was to stimulate and establish control in the sacrum. Therefore, the first sessions were devoted to learning the sensation of kicking the floor. His kicks had no force and manifested no imporvement in coordination until his sacrum was unlocked by having him [correctly] push a heavy object, in this case, a piano, thus forcing action through the sacrum to the legs. (1972, p. 115)

In this brief sequence Espenak demonstrates her use of the diagnostic movement test as her guide to the psychomotor needs of the patient. She saw tension in the musculature in the areas of the sacrum, and splits in the integration and coordination of the patient's body parts, legs independent of torso and head and shoulders as a separate unit. From this body analysis she decided to start by stimulating sensation and control in the sacrum area. She had the patient kick the floor as a means of releasing tension in the constricted sacrum. However, when this was unsuccessful, she suggested another movement configuation, a push, which brought about immediate results. Then, after she worked with O. to release specific areas of tension and facilitate control of new areas of the body, O. brought a record to the session for improvisation. Upon moving to this record, he displayed his anger in a new and direct way. He revealed new areas of constriction in the upper chest and neck. Therefore, revitalization of these areas became the next step in treatment.

In her continued work with O., Espenak also used relaxation exercises which helped to bring O. in touch with these constrictions in his body and the need to relax in these areas. Espenak notes that as a result of these structured movement sequences and the relaxation exercises, there was an increase in the scope, both physically and imaginatively, of his improvisations.

Once this physical improvement in coordination with the subsequent increase in self worth was achieved, a creative approach to reach him emotionally was introduced. O. was encouraged to imagine and imitate the ruler of Egypt—the Pharaoh. In watching O. put this image into action, it was clear that he had found a new sense of power (Espenak, p.c., 1987), and that this new feeling about himself could be further encouraged by the acting out of creative imagery. The sequence that emerged was:

1) building strength, awareness and relaxation into specific areas of the body;
2) suggesting certain movement sequences which affect the areas of the body where excess tension or numbness has occurred; and
3) using improvisation and music as a way to actively integrate the body's newly released energy sources into creative, expressive dance movement.

In this brief sequence, Espenak started by teaching or initiating specific movement sequences, in this case kicking the floor and pushing the piano. She had a specific plan in mind regarding which muscles needed usage and strengthening and which muscles needed release.

Movement Diagnostic Tests

Espenak developed a set of Movement Diagnostic Tests for use with all her clients, both the mentally retarded and the emotionally disturbed (1970). She describes the background that led to the development of the tests as follows:

> Wigman's work was wholly of a creative nature built on Laban's theories, giving it structure. Using this in a medical setting, as in the Clinic for Mental Retardation, forced me to adapt the material to more scientific use—hence, the formula Observation-Diagnosis-Treatment, as in other therapeutic processes. This gave birth to the Diagnostic Tests. (Espenak, 1985, p.c.)

The Movement Diagnostic Tests are grouped into six basic categories that provide information about "the positive and negative components of the patient's personality" (1970, p. 10).

The first category deals with emotional response, and consists of two tests. Test 1A, "Body Image," is a muscular test in which the patient is asked to walk on his/her toes. The patient's posture during this activity, Espenak finds, reveals information about his/her ego strength and self-assertion. Test 1B, "Emotional Response (Spatial Relationships)," involves improvisation, either in the form of free interpretation of music or through the use of suggested themes, images, and/or symbols, which would relate to the patient's life. This provides information about "the life style and emotional climate of the patient" (1970, p. 10).

Test II, "Degree of Dynamic Drive (Force Adjustment)," demonstrates "the physical and motivational energy applied in performance of a task" (1970, p. 10). In this case, the task is pushing a heavy object. Espenak finds that the degree of energy displayed by the patient can indicate the degree to which he can be challenged by the therapist.

Test III, "Control of Dynamic Drive (Rhythm, Time Concepts)," deals with the patient's sense of time.

Liljan Espenak demonstrating one of her diagnostic tests.

> Control and organization of time reveals both the individual's inherent personal rhythm (as a sum total of his personality) as well as his ability to adjust to any given organization from outside (i.e., to cooperate), whether or not this has as yet been carried out in everyday life. (1970, p. 11)

This test stresses breathing as the most natural rhythm in one's life and thus an indication of one's inner feelings. Breathing is closely interconnected with both physiological and emotional changes in the body.

Test IV, "Coordination (Body-Awareness and Locomotion)," is a test of the patient's movement-flow as indicated in walking.

> In normal locomotion, the sacrum performs a small wheel-like movement which allows a smooth and relaxed change of weight from one foot to another. In case of disturbance this wheel-like action will be hampered and the execution will be jerky or rigidly inactive. (1970, p. 12)

Espenak sees coordination as the physical expression of the individual's mental and emotional control. "The movement of walking is . . . the best natural demonstration of . . . the interaction of body and mind" (1970, p. 12).

Test V, "Endurance (Constancy)," measures the patient's "kinesthetic drive combined with mind control, endurance" (1970, p. 12). It utilizes various tolerance tests, including the use of repetitions of movement, to determine the patient's attention span, ability to concentrate, and tolerance for frustration and stress.

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Test VI, "Physical Courage (Anxiety States)," measures the patient's ability to perform movements that may seem somewhat threatening. These include "walking backwards, walking a spiral leaning more and more towards the center (experiencing force of gravity), and several floor exercises, rocking and rolling backwards" (1970, p. 12). Anxieties relating to movement, such as fear of falling or running downstairs, are closely linked to the fears the patient experiences in everyday life.

Summary

Liljan Espenak, a pioneer in the field of dance therapy, developed and directed the first dance/movement therapy post-graduate training program in the early 1960's, both academic and practicum. The program was in existence until 1981, when she discontinued it in order to devote her time to reaching a broader field of students through weekend workshops in the States and abroad.

In addition, Espenak has organized conceptual formulations which integrate her findings from her Diagnostic Movement Tests into a complete psychomotor therapy treatment program. The goals of her work are to integrate and strengthen both mind and body, believing that one deeply influences and is intricately connected to the other.

Finally, Espenak is particularly noted for her excellent integration of Adlerian psychological concepts into both a theory and therapy of mind and body.

SECTION B

Major Pioneers on the West Coast

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Mary Whitehouse

Mary Whitehouse (1911–1979) was a major dance therapy pioneer who worked and taught on the west coast. Her teachings have profoundly influenced many major contemporary leaders in the field. Whitehouse, whose early work began in the 1950's, wrote, "Odd, but I turned into a dance therapist without realizing it, simply because no such thing existed when I started" (1979, p. 51). She knew something was different in her teaching of dance, but didn't have a name for it. Later she came to call her work "movement-in-depth" (Wallock, 1977).

During this early period, Whitehouse read an article on dance therapy written by Marian Chace. Her response to the article was one of acknowledgment: she realized for the first time that she was not alone, that others were also using dance as a way to reach people on new levels. The individuals working with Chace, like those who came to Whitehouse, had little interest in dance as performance. They were seeking something deeper.

Whitehouse worked both one to one and in groups with individuals whom she considered to be fairly well functioning. She believed that the early pioneers in the field differed from each other greatly according to the population with whom, and the setting in which, they worked. Whitehouse frequently worked with dance students in her own studio.

Whitehouse believed that with students, a greater emphasis could be put on uncovering unconscious material; whereas with hospitalized patients, due to a more fragile ego structure, greater stress needed to be placed on emotional support and providing patients with more structured forms of expressive movement. While both populations rely on the strengths of the therapist during sessions, students generally, she contended, could tolerate less therapist direction and more psychic probing than hospitalized patients.

Many of Whitehouse's dance students were already involved in verbal psychotherapy, and thus frequently possessed both a movement and psychoanalytic vocabulary prior to their work with her (E.L. Lukas, 1963). This often assisted them in utilizing the Whitehouse method of self-discovery through movement (Whitehouse, 1963).

Two major areas of study influenced the work of Mary Whitehouse. The first was her intensive study of modern dance at the Mary Wigman School in Dresden, Germany. The second was her own experiences in Jungian psychoanalysis. Of her Wigman training, she wrote:

> The Wigman training prepared me for a particular approach although I did not know it at the time; it made room for improvisation, placing value on the creativity of the people moving. It assumed that you would not be learning to dance if you had nothing to say. (Whitehouse, 1979, p. 52)

Although she also studied with and was greatly influenced by Martha Graham and others, it appears that her work with Wigman left the deepest imprint. She states:

> I came home from Germany with improvisation so much a part of my training, so available to me as a teacher, that I was appalled to find that it was not accepted over here. Now it is the other way around, nobody wants to stand still for a plie because they are so busy being expressive. (Wallock, 1977, p. 69)

In the 1950's and early 1960's, Whitehouse went through a period when dance lost importance to her personally (Whitehouse, 1979). Later, as a result of her exposure to Jungian analysis, she came to view her own dance movement with increasing attention to symbolism and meaning. This revitalized her interest in dance as a form of self-expression, communication, and revelation.

At the same time, Whitehouse was also re-evaluating the word "dance" in terms of her teachings.

> Whatever it was, we were travelling away from dance. I had to call it movement. In order to find what it was that truly moved people, I needed to give up images in them and in myself of what it meant to dance. (1979, p. 53)

Whitehouse thought that the word "dance" denoted a finished product. She viewed the therapeutic use of dance as a process of delving unselfconsciously into the deeper layers of personality, the source of body movement (Wallock, 1977). Accordingly, she did not see this spontaneous type of movement expression as one that could be reproduced or repeated and still maintain the same depth of personal meaning. Hence, resulting from her own personal experiences with dance and movement, combined with her deeper insight into personality obtained through her exposure to Jungian analysis, she used the term "movement-in-depth" to describe this new level of dance-movement expression.

In later life, Whitehouse underwent a long struggle with multiple sclerosis. Faced with decreasing motor ability, she nevertheless continued her work. Her final sessions and her final writings were conducted from a wheelchair. Today, the work of Mary Whitehouse continues to have a major impact on dance therapy.

Theory

When asked to describe her theoretical model of dance therapy, Whitehouse began by stating her philosophical view of a theoretical model:

> I have to be honest—presenting a polished theoretical model to students interested in dance therapy, without admitting that it is achieved in the first place alone, with pain and struggle, may not be true for a second generation, but needs to be known. If it is not, such a theoretical model can be easily learned without any reference to personal gifts or

Mary Whitehouse in her youth as a dancer. (Photo courtesy Feather King.)

> temperament. It can be adopted wholesale and imposed on patients, as clearly as any teacher of dance takes an acquired style and imposes it on her students. (Whitehouse, 1979, p. 53)

As mentioned earlier, Whitehouse was most strongly influenced by her work with Wigman in the modality of dance-movement improvisation and her exposure to Jungian psychoanalysis. Through the integration of these, she developed a unique theoretical and practical approach to dance and movement therapy. The major issues relevant to her approach are: 1) Kinesthetic Awareness; 2) Polarity; 3) Active Imagination; 4) Authentic Movement; and, 5) Therapeutic Relationship/Intuition.

Kinesthetic Awareness

Kinesthetic awareness is, Whitehouse believed, the individual's internal sense of his/her physical self. She believed that some individuals naturally had more kinesthetic sense than others but that in either case it could be awakened, developed, and encouraged (1963).

> . . . if kinesthetic sense is never developed, or seldom used, it becomes unconscious and one is in the situation . . . that I can only call living in the head, which fact the body faithfully reflects, since it must move, by acquiring a whole series of distortions, short circuits, strains and mannerisms accumulated from years and years of being assimilated to mental images of choice, necessity, value and appropriateness. (1963, p. 6)

Whitehouse discusses kinesthetic awareness as the individual's ability to make a "subjective connection" (1963, p. 11) with how it feels to move in a certain way. She contrasts kinesthetic sense with exercises which encourage muscular release but without the "corresponding experience of . . . personal identity" (1963, p. 11). Whitehouse believed that it was not enough to work with the body mechanically, facilitating release as if the body were an object on which things occurred with no subjective responses. Instead, Whitehouse stressed the body as the subject/organism which personally reacts and responds to everything that happens.

Polarity

Whitehouse believed, along the lines of Jungian thought, that polarity is present in all aspects of life and emotions.

> Applied physically, it is astonishing that no action can be accomplished without the operation of two sets of muscles—one contracting and one extending. This is the presence of polarity inherent in the pattern of movement. (Whitehouse, 1979, p. 55)

Influenced by her Jungian training, Whitehouse put special emphasis on the concept of polarity and how it affects the functioning of the body and mind, as well as how one can observe polarized drives during the dance therapy process.

Whitehouse (1979) stressed that things are never black and white in life. That is, while we may be forced to choose one path in life over another, or one form of expression over another, the one not chosen for conscious expression does not go away, it simply goes unrecognized.

Moreover, in its disguised and unconscious state, it continues to exert pressure and create conflict.

Because dance inherently engages opposites, ". . .a dancer does not stop to think of curved/straight, closed/open, narrow/wide, up/down, heavy/light—these are a myriad pairs" (1979, p. 55), the dancer automatically engages in polarized expression. Hence, the modality of dance is perfect for the spontaneous release of opposing drives.

Active Imagination

Active imagination, the third aspect of the Whitehouse method, grows out of her concern for kinesthetic awareness and polarities. Active imagination, a Jungian method of freeing one's associations to allow in all levels of conscious and unconscious experience, was applied by Whitehouse physically in the dance therapy process.

Whitehouse stated:

> . . . the inner sensation, allowing the impulse to take the form of physical action is active imagination in movement, just as following the visual image is active imagination in fantasy. It is here that the most dramatic psycho-physical connections are made available to consciousness. (Wallock, 1977, p. 48)

Whitehouse's basic goal was to release unconscious emotions which she believed became "buried in the body, in tissues, muscles, and joints . . ." (Wallock, 1977, p. 50) that is, to make the unconscious conscious. She believed that this could occur if the individual was provided with the proper supportive environment, movement vocabulary, and facilitation (see Methodology below). Active imagination facilitates this process as follows:

> While consciousness looks on, participating but not directing, cooperating but not choosing, the unconscious is allowed to speak whatever and however it likes. Its language appears in the form of painted or verbal images that may change rapidly, biblical speech, poetry (even doggerel), sculpture and dance. There is no limit and no guarantee of consistency. Images, inner voices, move suddenly from one thing to another. The levels they come from are not always personal levels; a universal human connection with something much deeper than the personal ego is represented. (1979, p. 58)

In this quote, Whitehouse is describing the psychoanalytic practice of releasing repressed unconscious material through the process of loosening and relaxing the ego's defenses against spontaneous expression. In addition, she is supporting Jung's concept of the personal unconscious being united with an unconscious that extends beyond the personal self to a universal or "collective" unconscious. Finally, she is pointing to the importance of the conscious self, or ego, as the observer who watches and participates but does not censor or control the individual's physical expressions. In one sense, she is describing the process of building the powers of the observing ego through the mechanism of freeing associations by way of body movement. In another sense, she is describing a spiritual process of expressing universal forms which would not normally be part of one's conscious movement repertoire.

Through the process of active imagination in movement, Whitehouse believed that one could experience what Jung called the "Self." The "Self," with an upper case "S," stood for the unconscious that goes beyond the immediate and personal concerns of the ego, that is the self, with a lower case "s". When Whitehouse spoke of the "Self," she was referring to a specific Jungian definition of the unconscious. However, Whitehouse did not develop a more clear or concise definition for this concept. Zenoff (1980, p.c.), one of her proteges, said of Whitehouse's work:

> She resisted talking about theoretical concepts. "You don't have to understand it—it is the beauty of the unknown." When I tried to pin her down, I felt scattered, but she had a focus, even if I couldn't comprehend it.

Many of Whitehouse's students, now major leaders in the field, have studied Jungian psychology in depth and have attempted to broaden and clarify many of these concepts as they relate to the expressive movement process.

What is clear is that active imagination can become a movement experience only if it is expressed on a level of movement that is not consciously directed. This level of movement Whitehouse called "authentic movement." The term authentic movement was first used by John Martin in 1933 to describe what he witnessed and experienced while watching Mary Wigman perform. In light of Wigman's profound influence on Mary Whitehouse, it is not surprising that Whitehouse described her students' movements by the same term. Today when the term "authentic movement" is used in dance therapy, it often refers specifically to the Whitehouse approach.

Authentic Movement

Authentic movement is necessary if active imagination through the musculature is to take place. Whitehouse described authentic movement as being

> . . . in and out of the Self at the moment it is done. Nothing is in it that is not inevitable, simple . . . undiluted by any pretense . . . . It can be just one hand turning over, or it can be the whole body [in motion]. (Fay, 1977, p. 69)

Whitehouse contrasted authentic movement with its opposite, "invisible movement" (Whitehouse, 1979, p. 57). Invisible movements are movements which lack a genuine emotional charge. The word "invisible" referred to the invisibility not of the muscular action but rather of the underlying emotions or thoughts which the movement fails to express. Instead, a stylization of action or muscular rigidity is visible. Whitehouse believed that this basic difference in movement quality was, again, a demonstration of polarities, a tendency to express and a tendency to repress or hide.

In order to clarify the qualitative difference between these two levels of movement, Whitehouse (1979) used the term "I am moved" to describe the experience of authentic or visible movement, and the expression "I move" to describe controlled or invisible movement. She explained that "'I move' is clear knowledge that I personally, am moving. I choose to move . . ." (1979, p. 57); whereas "I am moved" is a moment when the individual relinquishes control and choice, allowing the "Self" precedence in moving the body freely. Whitehouse described this process as "surrender that cannot be explained, repeated exactly, sought for or tried out" (1979, p. 57).

It is interesting to note that in an unpublished article (prepared for the Analytic Psychology

Mary Whitehouse conducting a group in her California studio. (Photo courtesy Feather King.)

Club, 1963), Whitehouse made a statement not seen in her later publications but significant to understanding the development of her theoretical framework. She did not make a clear distinction between the movements of the conscious self and the movements of the unconscious self. She states:

> The core of the movement experience is the sensation of moving and being moved. . . . Ideally, both are present in the same instant and it may be literally an instant. It is a moment of total awareness, the coming together of what I am doing and what is happening to me. It cannot be anticipated, explained, specifically worked for, nor repeated exactly. (1963, p. 4)

In this quote, Whitehouse describes the experience of authentic movement, though this label is not yet used. Compare her statement here, "It cannot be anticipated, explained, specifically worked for, nor repeated exactly" with her later (1979) description of authentic movement as "surrender that cannot be explained, repeated exactly, sought for or tried out" (p. 57). Although these two descriptions are almost identical, there is an important difference.

In her 1963 paper, there is an emphasis on the spontaneous synthesis in movement of "what I am doing" (i.e., "I move") and "what is happening to me" (i.e., "I am moved"). Whitehouse appeared to be looking for and appreciating a total and unified movement experience (authentic movement) in which there is simultaneous awareness of both "I move" and "I am moved." In her later literary contribution, however, authentic movement refers not to the unified movement experience described in her earlier writing but to a pure "I am moved" experience. In the later work, there appears to be more emphasis on the separation between "I move" and "I am moved," implying that any experience of the former would dilute the authenticity of the latter.

This difference seems to hinge on a changing definition of "I move." Originally, this term was used to describe an experience of myself moving that did not imply self-consciousness or external controls, but rather an observing part of self that looked on without directing or judging. Later, however, Whitehouse began using this concept to describe controlled "invisible" movements, which failed to express underlying ("authentic") emotions and thoughts. Thus, "I move" took on a totally different meaning, making if impossible to coexist with visible (authentic) movement.

It can be argued that this change is simply a matter of semantics. On the other hand, Whitehouse may have become more extreme in her later life in response to the dramatic and tragic physical changes she experienced during her long struggle with multiple sclerosis. This must have had a profound influence on her perceptions, and may have led her to emphasize the "I am moved" experience.

It is likely that Whitehouse viewed the movement process as a continuum ranging from one polarity (invisible movement of the conscious self) to the other (authentic movement of the unconscious self), and stressed varying degrees of each depending on the individual's needs at different times. It seems clear, however, that Whitehouse never wanted to *totally* remove consciousness from movement. Given her belief about polarities that "there is no such thing as choosing only one end of the scale" (1979, p. 55), it is more likely that she wished to unite these opposites, to achieve a total awareness that encompassed both conscious and unconscious movement.

During improvisational work, Whitehouse did help individuals to temporarily relegate consciousness to a silent observing role, thus allowing the unconscious to express itself via authentic movement (active imagination in movement). However, this does not necessarily mean that the authentic movement process is totally unconscious. Although the unconscious is given free rein to express itself, the conscious mind is still present in a silent observing role, "participating, but not directing, cooperating but not choosing" (Whitehouse, 1979, p. 58). If the conscious mind is "participating" and "cooperating," there must be some element of "I move" present during the "I am moved" experience. It is possible, therefore, to conclude that Whitehouse did not aim to guide her clients to one extreme end of the movement continuum, but rather to help them find a point along the continuum, or perhaps transcend it, where "I move" and "I am moved" coexist and can be simultaneously experienced.

Therapeutic Relationship/Intuition

The foundation of Whitehouse's approach to dance therapy was her stress on the therapeutic relationship and intuition. She believed that the therapist was at different times a teacher, a mediator, and a leader (Wallock, 1977). Her approach to the therapeutic relationship was first trusting her own intuition, then helping the client to trust his/her own intuition, and finally emphasizing the therapist's ability to begin at the level of readiness that the client presented.

> Starting where the client is can only mean willingness to be anonymous oneself in favor of observing, quickly and without barriers, what is available to that individual. (Whitehouse, 1979, p. 60)

Whitehouse stressed that this seemingly simple process was often quite difficult to accomplish. It required that the dance therapist put aside preconceptions of what the client should do, and instead, take the role of not knowing what is correct for a particular individual, letting the individual find his/her own solution.

Whitehouse emphasized two concepts in her approach which may seem contradictory, yet with deeper examination prove complementary. The first is the skill of the therapist in exerting restraint while the client initiates his/her own movements and/or thoughts. The effort to start where the client is means waiting for the client to evolve and shape his/her own movements without imposition or direction from the therapist. The non-direction of actual movement sequences is translated to the client as room for internally prompted movement.

The second is for the therapist to trust his/her intuition in directing the client while being prepared to accept the client's own judgment as to whether these directive suggestions are helpful or not. Rooted in this approach is the therapist's own security and non-defensiveness which allows the client to respond either positively or negatively to the suggestions and to the therapist.

What superficially appear to be opposing rules of thumb are actually the therapist's considerable skill in perceiving the point at which therapeutic intervention is needed, and moments in which waiting patiently is more productive.

Methodology

The intervention styles of Whitehouse, similar to the other pioneers in dance therapy, were at times directive/externally prompted, or non-directive/internally prompted, or a combination of the two. This was determined by the client's readiness and needs. In her publications, Whitehouse emphasized the importance of the quality of the therapeutic relationship, without which, she believed, the therapeutic movement process would not unfold.

Whitehouse stressed the role of the therapist as the mediator and mirror. Although she did not give an exact definition of what she meant by mediator, she did give the following statement in her interview with Wallock (1977) which elucidated her thoughts on the role of the therapist as the mirror.

> It is as if there is a certain amount a person can do alone and beyond that they have to come to somebody else to really see what they are doing. . . . I often experienced my eyes as the eyes that were looking so that the person could shut his. Much of the movement was done with closed eyes, even when up on the feet. . . . Somehow, if I were looking, the person could afford to let go and let it happen because I was watching. (p. 72)

Whitehouse's major contribution is in a style of intervention rather than an emphasis on particular techniques. She once stated, "I have an approach, not a method, much less a theory" (1963, p. 3). Whitehouse's major mode of intervention, which has become very influential among those contemporary dance therapists who work in private studios, was active imagination through the medium of movement. The various techniques she used to begin sessions all aimed to eventually lead her clients to improvisational work, through which the active imagination process could be expressed.

Whitehouse often started a session by offering a quick choice to the client, for example, "What would be most comfortable, easiest—lying, sitting, standing?" (p. 60). She found that individuals differed in their choices of a starting position and that providing a choice gave the individual a chance to make an independent decision about how he/she was most comfortable, and in what direction the session would go. In this respect, Whitehouse's approach was primarily a client-centered one.

Another way Whitehouse began sessions was by teaching dance technique and/or simple movement tasks or ideas. She drew primarily on Graham's technique, but her style of imparting this technique was uniquely her own. Whitehouse stressed that teaching dance technique and providing simple movement tasks gave the client a feeling of self-confidence as well as greater kinesthetic awareness, and thus facilitated the move to more difficult tasks or ideas.

Some of her proteges, such as Jane Manning and Judith Fried (1985, p.c.), believe that Whitehouse's greatest gift was her ability to transform the learning of dance technique into a deeply personal and emotionally unifying experience. Their memories of Whitehouse focus on her use of dance technique and simple movements as a way of getting clients in touch with their inner feelings and thus preparing them for in-depth improvisational work.[1]

An example of starting sessions with simple movement tasks might be the use of warm-up structures. For example, she might suggest that clients work first only with specific body parts (arms, legs, face) or she might encourage using only the right side or left side of the body for a certain movement theme (Zenoff, 1980, p.c.)

Whatever the style of opening a session, the client at some point will usually need help deciding on the next step. Whitehouse acknowledged the responsibility the therapist faces in helping the client become sensitive to and able to express his/her own movement process. It is in this situation that the therapeutic relationship becomes essential, with intuition guiding the therapist in deciding whether or not intervention is needed, and if so, what kind of intervention would be most helpful.

Whitehouse assessed the clients' ability to allow movements and ideas to flow freely. Sometimes she utilized music to encourage individuals to begin to dance whenever they felt their own movement process so inspired. If she saw that a client was capable of allowing a free flow of thoughts and feelings in movement, she then provided an unstructured environment within which the client could make all of his/her own movement decisions.

When this was not possible she would provide movement themes or broad creative structures within which the client could project thoughts and feelings through movement. For example, to provoke imagery and associations she might suggest they were in a cocoon and then ask if it was large or small, stiff or soft, unyielding or flexible.

This technique is referred to in psychotherapy as a projective technique. It was commonly used by dance therapists to facilitate expression and insight, but was initiated in many different ways. This creative and exploratory style of intervention was an integral part of the creative and modern dance movement from which dance therapy was built. It appears that, for the dance therapist, the use of the projective technique was as natural as the use of dance itself.

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[1] Not all of Whitehouse's proteges stress this concrete, body-oriented side of her work. Others, such as Joan Chodorow, Nancy Zenoff, and Janet Adler, remember her as focusing primarily on improvisation and the integration of abstract Jungian concepts with body movement. Because of these two differing views of Whitehouse, when many of her former students get together and discuss her work it often seems as though they had studied with two different teachers (Manning, 1985, p.c.).

Whitehouse used metaphors and projective technique in movement improvisation. In the following example, she gradually adds more personal levels of content to her initial use of imagery.

> . . . work begins on the floor, focusing quickly on the opposites involved in up/down. Each is explored. . . . Everyone then goes on to discover the movement possibilities of the continuum on which up and down exist. . . . This brings a pair of opposites into contact with each other. The third stage. . . . introduces an image . . ., "The earth is my mother. The sky is my father." (Whitehouse, 1979, p. 66)

Here, after the initial images of "up" and "down" had already begun, Whitehouse suggested the concept of earth/mother and sky/father. In this way she added possible personal symbolism or meaning to "up" and "down" for those who could make use of it.

Whitehouse rarely (if ever) spoke while a client was involved in a movement improvisation, but if a client stopped and Whitehouse believed the individual needed help she might ask certain facilitating questions such as, "What happened?", "Where did you go?", "What did you find out?". From the information she received she would then make suggestions or ask questions to help the client deepen and/or focus his/her movement explorations (Zenoff, 1980, p.c.). One way she had of making suggestions was through observations of the individual's movement, such as "I saw at a specific moment when your feelings changed and looked free," "What did you think when you moved your arm upward?" In other words, Whitehouse commented on what she saw in a way that was not an interpretation of the meaning of the movement but rather a comment on the movement sequence as it was observed by her (Zenoff, 1980, p.c.). During these pauses in the movement improvisation, Whitehouse stressed the importance of talking in order to understand and integrate verbally the psychomotor events. She then frequently utilized the material that surfaced to structure a theme on which the next or continuing improvisation might focus. As Adler (1980, p.c.), a protege of Whitehouse, has said, "She encouraged talking to integrate what happened into the individual's consciousness; she was not impressed with catharsis alone."

Although Whitehouse did not actually dance with her clients, she did move toward them at moments when support was needed. Aside from these moments she basically stayed on the periphery but, according to Zenoff:

> I always felt she was right with me; I experienced her presence very deeply and it allowed me to go into myself and my movements. You could feel her empathy even toward the end of her life when she was in a wheelchair. Her presence was part of the healing process. (Zenoff, 1980, p.c.)

The following case example demonstrates the active imagination process through body movement. It also demonstrates Whitehouse's style of letting the patients begin in the fashion that they choose and then working with them patiently as their movements develop. Special emphasis is placed here on the therapist's ability to wait and create a milieu that allows the individual to find his/her own unique style of expressive behavior at his/her own pace.

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Mary Whitehouse. (Photo courtesy Feather King.)

> I remember a dancer who came to the studio regularly. We had been working with the pull of gravity. One morning she sat on the floor with her arms on her bent knees and I put on very slow music. . . . I said, "Don't assume it's fast or slow, don't assume it's down or up, don't assume anything. Just begin where you are." (Wallock, 1977, p. 70)

The following describes in Whitehouse's words the client's reaction:

> To her amazement, very slowly, like an iceberg moving a glacier, she rocked to the right and to the left, back and forth and when it came to the point of falling, she fell and the energy rebounded in her body and she rolled, rolled, rolled across the floor. She sat up white-faced with surprise. The falling did not strike her as anything special but she was absolutely unprepared for the rolling. That's what I mean by catching me and the person by surprise because the process that is the movement has really moved them. Sometimes it happens, sometimes it doesn't. It is a kind of openness that is willing to allow something to happen as well as not to happen (Wallock, 1977, p. 70)

It is this giving in to the spontaneous movement process that Whitehouse spoke of as a precursor to the surfacing of images from the unconscious layers of the psyche. In other words, the active imagination process implemented itself through the modality of authentic movement.

The next case example demonstrates one client's ambivalence toward this unfolding process as well as Whitehouse's conceptualization and interpretation of the client's imagery during the session:

> A young woman stood at the edge of the big studio. In front of her there seemed to be marshes—water lay everywhere but there was enough dry land to pass through [active imagination]. She crouched, carefully putting one foot in front of the other, proceeding out into space. The water seemed to come up around her; she felt as if it engulfed her and said to herself, "Oh, I must try to make friends with it." She sat down, allowing the water all around her body but not her head. No matter how she played, . . . [her] head took no part . . . At last she . . . said, "No, no,". . . . (Whitehouse, 1979, p. 58)

In this example of active imagination, Whitehouse pointed to the Jungian symbol of going into the water as dipping into the unconscious parts of the personality. This patient would only go so far. She protected symbolically the mental or rational part of herself by not relaxing her head, but rather straining to keep "her head above water." In this way she fought against allowing herself to become completely in her unconscious.

In Whitehouse's subsequent session with this woman, all of her images had stopped, no material was coming into consciousness. Whitehouse (1979) suggested that "we go back to the water and the marshes" (p. 58). In response the client walked to the middle of the studio and immediately was able to re-experience the water. The events that followed demonstrated this individual's conflict about entering the unknown realms of her unconscious.

> She lay flat this time, playing in it with her hands. It was very shallow, barely covering the ground and not going anywhere . . . again came the feeling of the head resistance . . . suddenly she could not bear it; she got up and walked away. This time she found herself in a burning desert. There was . . . absolutely nothing but the heat. . . . She said she was clawing in the sand to get at the water beneath the surface, longing to find it . . . despairing because it had disappeared. (1979, pp. 58–59)

This case demonstrates what Whitehouse must have been referring to in her use of the word "mediator." As she stood observing and experiencing with her client, she acted as the mediator between this individual's opposing drives, that is, the drive to express versus the drive to repress thoughts and feelings. Although it was difficult to leave the client in this desperate state, Whitehouse believed in the process and the natural timing of the client and did not attempt to facilitate or control the client's response. Instead, Whitehouse empathized with her struggle and despair and thus encouraged her to meet the depths of the unconscious when she felt she was ready. At the same time, she permitted the client to maintain her defenses and conscious controls over potentially overwhelming body movements and emotions. In this way, through her empathic rapport, she mediated the client's opposing drives while simultaneously encouraging the client to make her own decision as to how far to go in either direction.

The two case examples cited above demonstrate Whitehouse's role as a patient, empathic observer. She encouraged and supported the therapeutic movement process in light of the individual's readiness for self-expression through this medium. Her role was one of being "with" the client as he/she encountered his/her own personal experience in both thought (imagery) and muscular (movement) themes.

Summary

Whitehouse was gifted in her ability to develop the Wigmanian improvisational approach to dance into an in-depth psychomotor therapy. She also had a deep respect for Jungian thought and was able to project her understanding of the power of movement into this framework. This merger of two powerful tools, expressive dance and Jung's active imagination, form the foundation of Whitehouse's major contribution to dance therapy.

5

Trudi Schoop

A major pioneer from the west coast, Trudi Schoop has made many unique contributions to the practice of dance therapy. As a result of her training and career as a mime, complemented by her wonderful sense of humor, she brings a personal versatility and flexibility to her interactions with patients. A book describing her work, written with friend and colleague Peggy Mitchell, was published in 1974. Much of the discussion that follows has been abstracted from this work, *Won't You Join The Dance?*

Schoop was born in Switzerland in 1903. At the age of 16, with no formal dance education, she held her first dance recital at the Schauspielhaus in Zurich. Though her debut was a tremendous success, she felt the need for technical training. In addition to her study of classical ballet, she familiarized herself with the pioneering dance forms that were prevalent in Europe at that time, including the methods of Wiesenthal, Duncan, and Laban (Mitchell, 1987, p.c.).

> My stage career was the strongest influence because there I built characters on the stage. I had to find out how they felt, how they would move, how they would behave. On stage I could abstract and objectify. (Wallock, 1977, p. 62)

Schoop's own personal experience with mime was one of externalizing or "objectifying" her own conflicts on the stage. "If other people could laugh, then the conflicts were not so terrible" (Wallock, 1977, p. 62). The combined use of mime and humor for the expression of conflict later became the two primary cornerstones of her dance therapy practice and two of her major contributions to the field.

Schoop began practicing dance therapy as a volunteer at Camarillo Hospital in California in the 1940s and later became employed there. Today, she teaches in France, Germany, Switzerland, Italy, and the United States.

Theory

Schoop believes that who we are is reflected and manifested in our bodies. In addition, what happens in the mind has a concomitant reaction in the body and what happens in the body has a concomitant reaction in the mind. For this reason, postural attitudes and physical

alignment are reflective of one's mental state. Furthermore, through the body and senses one formulates a mental picture of reality. It is the harmonious interaction between psyche and soma which promotes conflict free functioning (1979).

It is this harmony which Schoop finds painfully lacking in her patients. She sees in their postures all of the stresses and tensions indicative of internal conflicts, and stemming from opposing and repressed drives. Schoop believes that all individuals are pulled by opposites, "all individuals encompass the complete range of every feeling, action [and] thought. . . ." (1979, p. 37). But, due to societal taboos, one side of the individual must go "under cover."

> Hospitalized patients demonstrate clearly how devastating the toll [of this repression] can be. It's as if they have become one-sided; locked into a single feeling, all others consigned to oblivion. (Schoop & Mitchell, 1979, p. 38)

Schoop believed that in one form or another, the repression exerts pressure on the personality of the patient and in so doing undermines his/her integrity and performance. For this reason one of her major goals is to bring the patient's repressed side to consciousness through expressive movement.

In this connection, Schoop (1979) reflects upon the "UR experience." She describes this German word as follows:

> *Energy:* the vital force which keeps the whole universal complex on the move. From the microcosm of the atom to the magnitude of the great whirling bodies of matter in our heavens and beyond, there exists the ceaseless life-force of the UR Energy. (Schoop & Mitchell, 1979, p. 36)

Schoop also describes UR as endless space and/or endless time that continues with no apparent reason. She contends that man forgets nothing and "that deep within each human lies a recognition of the UR experience" (Schoop & Mitchell, 1979, p. 36), that is, the totality. It is her feeling that we, as humans, live on two levels; one is the linear day to day, and the other is the universal. She sees dance as one way in which we confirm both this finite (muscular level) and infinite (energy level) connection to life. In her lyrical and poetic manner Schoop connects the rhythmic contractions and releases, extensions and flexions that make up dance with the eternal rhythmicity of life (the UR).

Schoop (1976) explains the significance of the UR experience in terms of dance therapy as follows:

> When I am intensely present in all my multifaceted totality, I feel that I am in balance. Thus, my approach to my work becomes an "attitude" rather than a "treatment." The application of any one treatment form would get in the way of my trying to understand the ununderstandable. If I face a patient with the freedom of all my capacities intact, I can more readily detect in him the parts that seem to be intact, as well as those that seem

photos courtesy Peggy Mitchell

> to be different. . . . I can feel assured that the patient contains all the same elements or possibilities that we all have; they merely differ in duration, intensity, and arrangement. (p. 5)

In summary, Schoop has two major concerns, both of which revolve around opposites. The first is helping individuals to experience, in a harmonious way, their conflicting emotions. The second, an outgrowth of the first, is helping individuals connect, first to their own immediate reality, and then to the reality that goes beyond the daily—an experience of the universality and uniformity of all living things, past, present, and future. She believes that through the ability to contact the various sides and levels of one's own experiences, one gains a deep understanding and connectedness with all living things.

Methodology

An overview of the Schoop approach reveals a format and rationale that is in some ways similar to that of the other pioneers. Schoop stressed the importance of teaching proper body use in order to build the individual's capacity for self-expression and exploration. Through movement, she believed that one's self-esteem could be improved via more efficient physical functioning. After building the body image through expanding the movement repertoire, developing increased body awareness, and experimenting with postural attitudes, she gradually moved to thematic movement explorations which she often initiated herself. When it was evident that the patients' tolerance of dynamic movement expression had increased and they had developed a sufficient movement vocabulary, Schoop, like many of the other dance therapy pioneers, moved to spontaneous movement expression in the form of improvisation. However, in contrast, Schoop would stay in this mode only long enough to bring out new personalized material. As this material surfaced, Schoop helped patients to organize their new experiences through movement "performances", that is, the planned reproduction and repetition of movement themes (1974). The process of formulating dance/movement sequences served the function of slowing down the expressive process, and in this way allowed more time for the exploration of inner conflicts. Through choreographing conflicts, Schoop believed the individual could gain some control, insight, and mastery over his/her problems.

Schoop combines four methods of developing the physical and emotional expressivity of her patients: 1) the educational approach; 2) rhythm and repetition; 3) the inner fantasy; and, 4) spontaneous movement improvisation and planned movement formulation.

Educational Approach

Schoop would begin by lifting the taboos against emotions. She believed that before patients could gain muscular control over the expression of their emotions, they would first have to acknowledge their conflicts and then externalize them. She helped the patients achieve this through the use of humor and her own body. Schoop believed strongly in the healing aspects of humor, feeling that we all have much to laugh about, including the benefits of being able to laugh at ourselves. Because of her background in mime, humor was a vital part of Schoop and therefore naturally integrated into her work. The humor aspect of Schoop's work is usually only implied in her publications, but it is common knowledge amongst those whom she taught (Mitchell, 1987, p.c.). Like a good comedian, Schoop was able to abstract those universal aspects of personality and human conflict with which all individuals struggle, and put them in a form that caused laughter and self-acceptance.

Schoop demonstrates this aspect of her approach—and attitude toward life—in *Won't You Join the Dance?* (1974). She describes one of her initial sessions with hospitalized psychiatric patients. In this session she eagerly decided to demonstrate a movement tantrum in the hope that this would release the patients' extreme inhibitions around feelings of anger. After acting out a complete, lengthy, and exhausting tantrum, hoping that her withdrawn and solemn patients would be so moved that they would join her, she was instead greeted by blank stares and one slightly more aggressive patient who went up to her and asked, "Are you on Bennies?" (Schoop & Mitchell, 1974, p. 31). Schoop portrayed this colorful experience with humor and weathered the blow with minimal hurt. In spite of feeling a little foolish about this early plunge, she continued to develop her methodology by tailoring this original approach. Gradually she integrated her dramatic flair and her skills at characterization and emotional expression with her interactional skills and empathic nature. What emerged became the Schoop approach to dance therapy.

Schoop's skill at using herself actively, through drama and dance, to elicit the physical expression of feelings and ideas in patients has become one of the cornerstones of her work.

> She says the therapist should be like a very good actor. The patient will respond to the therapist if the therapist is really experiencing the feeling and projecting it fully, just as an audience responds to the feelings conveyed by a good actor. (Wallock, 1977, pp. 46–47)

In addition, by exhibiting various extremes of movement which served the purpose of exaggerating and reflecting patients' emotions, she helped them to laugh at, as well as accept themselves in a new, less judgmental fashion. This style of intervention paved the way for the acceptance of conflicting emotions, and in turn served to build an atmosphere of trust which freed patients to explore their own internal cast of characters and conflicts.

After the taboos against emotions were lifted and the patients were more ready to accept themselves, Schoop would proceed by helping them learn about and experiment with their own body movement. The goal here was to increase the patients' body awareness, physical control, and range of functional/expressive movement.

One method was the exploration of posture. To help the patients understand posture she used alignment exercises, integrated with the use of imitation, exaggeration, and humor. For example, she would have the patients imitate a posture and variations on common postures which she would deliberately exaggerate. She would also humorously imitate particular postures she saw in patients.

> It certainly seems that when I demonstrate a patient's physical manifestation *humorously*, he is confronted by an affectionate and amusing image of himself. The stinging seriousness of his conflict appears to be lessened, and for the time being at least, he doesn't have to defend himself against something when that "something" strikes him as funny. (Schoop & Mitchell, 1974, p. 76)

After this she would exaggerate opposing postural styles in order to help clarify the differences, and would encourage the patients to walk in various positions.

> We do the worst walks we can think of; we use every kind of ridiculous, overdone posture and gait, parading across the room pigeon-toed, splay-footed, knock kneed, bow-legged. We waddle, clomp, and mince. We enthusiastically make different parts of our anatomies stick out, sag, or flap. (Schoop & Mitchell, 1974, p. 86)

She would further suggest that the patients imitate others, such as people at the hospital, friends, relatives, people on the street, and so on. ". . . . no one escapes our alignment inspection" (Schoop & Mitchell, 1974, p. 86).

Besides teaching about posture, Schoop would help the patients identify with their own bodies through the use of verbalization. She utilized verbalization as a way to confirm and identify that a patient was in fact moving, by stating what part of the body was moving and how it was moving. For example, Eric swings his hand, Jane shakes her finger, Bill lifts his leg. After all body parts have been acknowledged in some action, she might play a waltz and then start a simple side to side swing which would gradually increase in size until all body parts were united and committed to a single action (Schoop & Mitchell, 1974). Then she would encourage the patient to say, "This body that swings is mine, I am swinging" (Schoop & Mitchell, 1974, p. 102).

> To stress individual differences, I ask the patient to see and touch another person's body just as he learned to see and touch his own. As two partners face each other, I can give each one a different way of moving: round movements vs. angular, soft vs. staccato, slow vs. fast. Or they may show each other different expressions: silliness confronting sadness, boredom looking at happiness, anger watching friendliness. There is no end to the distinctions that can be made between the You and the Me as the patient struggles to develop a sense of identity. (Schoop & Mitchell, 1974, p. 102)

Another educational technique used by Schoop was the exploration of contrasting pulls in the personality. Her incorporation of contrasts into dance/movement therapy techniques has been one of her major contributions, and is a style of working that is well-known and used by contemporary second and third generation dance therapists. The following describes one method Schoop uses to explore opposing pulls in the personality:

> . . . I purposely create split tensions in the bodies of my patients to make them conscious of what they are doing unconsciously. Energy-splitting can become quite a hilarious game, more difficult than you might think when it has to be done intentionally. In the course of a session, I may pick up split-body conditions that are being manifested by members of the group, or I may rely on my own collection of "standard splits." We can move around with tight, contracted bodies or skip with "ragdoll" arms and stiff "wooden" legs, or run with one whole side rigid and the other side loose. (Schoop & Mitchell, 1974, p. 108)

After she has encouraged a split-body exaggeration, her goal then is to bring back unity and unison. Through the exaggeration of splitting the subsequent reunification can be made easier.

> As a beginning, I've found it best to work from the two extremes of tension. Almost anyone can grasp the idea of tightness or looseness, and can make himself stiff, or limp all over, and then jump, or run, or dance about. When the patients are well acquainted with those two extreme possibilities, then they can be introduced to the degrees that lie between

> them. From the tightest, I can then ask for less . . . less . . . still less . . . and finally, least. And from the loosest, more . . . more . . . still more . . . and finally, most. The body becomes more flexible as the patient practices the tension scale, and the patient can find that one degree in which his body feels most comfortable. He discovers his functional, basic level of energy. (Schoop & Mitchell, 1974, p. 109)

In the above passage she is describing her "outside-in" approach. It combines the process of educating and sensitizing the body to one's active use of physical control. With this exercise she is both supporting and teaching self-control through encouraging the mastery of physical extremes.

Schoop then guides the individual back to a more fully unified physical state.

> At last the whole body is ready to experience one degree of tension, sustain one level of energy throughout. To capture this oneness, I can adapt the entire body's tension to the tension in one of its parts. Starting with a clenched fist, for example, we lead the tension being felt by the hand into the whole arm. We move it across the chest and shoulders—involving the head en route—and down into the other arm. It is then spread downward through torso, legs, and feet until the entire body feels like a fist. (Schoop & Mitchell, 1974, p. 109)

Rhythm and Repetition

Schoop's use of rhythm and repetition has many variations, but can be broken down into three basic approaches.

Using the first approach, externally prompted rhythmic action, Schoop would generate the expression of a particular emotion by performing its universally associated action. The patients would then pick up on this through imitation. For example, to generate the expression of anger she would have the patients repeat actions such as kicking or punching. In this way, she would lift the taboo from the emotion by giving the patients permission to express it physically.

Next, she would transform this direct release of emotion into dance form by adding the rhythmic component to the expression. This provided the patients with the tools to break the emotion down into its component muscular actions or specific muscular drives, thus facilitating externalization, control, and mastery of expression.

This process leads to a neutralization of the often overwhelming emotion, which provides the patient with the necessary cathartic release but without the possible loss of self-esteem which might otherwise emerge in such emotional discharge. Now the patient has access to his/her emotions and has also acquired a new skill in movement. Schoop has now achieved her goal of unlocking the hidden side of the personality through non-threatening means and cultivating this release through the positive reinforcement of the joy of self-expression and self-affirmation. The patient now has the movement tools necessary for communication and expression.

In the second approach, Schoop would take an educational role. She might request that the patients choose a feeling, whether they felt it or not, and develop it fully into dramatic movement expression which stressed rhythmic release. They were asked to work on it, repeat it, and develop it until they were satisfied with the result. Like an artist, their task was to complete a finished product. If the emotion became personalized for them it was okay, but

Trudi Schoop conducting a large group dance therapy workshop. (Photo courtesy Trudi Schoop.)

that was not the goal (Mitchell, 1985, p.c.). Instead, the goal was to build a flexible and strong expressive movement vocabulary. Schoop believed that this would generally prepare the individual for a more open, relaxed acceptance of life situations and emotions as they arise. In this way, the individual's need to block or deny circumstances which may arouse charged and disturbing thoughts and feelings would be reduced. This approach also built the individual's sense of control and mastery over emotional expression.

These exercises encouraged structured avenues of self-expression which provided: 1) a sense of self-control; 2) trust of the body and therefore a deeper indentification with one's physical self; and 3) flexibility and strength in coping with life experiences.

It was a fundamental concept of Schoop's that we all have rhythmic ability which at times seems inaccessible because it is repressed (Schoop & Mitchell, 1974). Her third method helped patients to release and explore their innate rhythmic motions.

For example, she might ask the patients to act out various daily tasks such as combing their hair or getting dressed. In so doing, they were taught to become aware of their internal rhythm.

> For as long as necessary, the patients walk at their own speeds, clap their own rhythms, stamp in their own qualities and time patterns, without being dominated by music, drum, or me. (Schoop & Mitchell, 1974, p. 119)

Thus, Schoop would begin by sensitizing the patients to the every day rhythmic actions in their lives. They may not have previously been aware that these actions had any rhythmic value. After this was accomplished she would proceed to the next, more subtle level of rhythmic awareness, the pulse. She would ask the patients to take their pulses and sound out each beat.

> After a while, all pulses are located, and the hall is filled with rhythmic sounds—some slower, some faster; some higher, some lower. . . . Soon the sounds even out, the fast ones slowing down and the slow ones speeding up, until all the voices are sounding in unison. At that point, the drum or the pianist can take over, continuing the rhythm created by the patients themselves. When the beat is firmly established, I can ask them to move their body parts to it. The fact that they are interpreting their own rhythms, not mine, makes them enjoy the performance much more. (Schoop & Mitchell, 1974, p. 119)

As in her other approaches to developing rhythmic awareness in patients, Schoop again would break down the rhythmic process into smaller parts. That is, she would start with individuals' beating out rhythms with beaters and body parts (arms, legs, etc.). Gradually, as a sense of security in rhythmic production was attained, the rhythmic action would move to the entire body, including the vocal chords, through the emission of sounds. In addition, she would subtly lead this into a group action by having the pianist pick up on the emerging rhythmic pulse. As a result, a strong group rhythmic activity would develop, supported externally by the piano.

The merging of the group spirit was made possible as a result of the group's previous work on developing their own individual rhythmic awareness. Here one can see parallels between Chace and Schoop regarding their approach to the group. Both placed initial emphasis on registering and facilitating the expression of individual needs within the group, and then gradually modified and organized these needs into united, empathic, rhythmic group action.

The process continues; Schoop explains:

> From rhythmical acceptance, we can move to rhythmical disagreement. I ask the patients to oppose my steady drum beat with their beaters: faster or slower or louder—whatever way they feel like beating, as long as it goes against mine. The room clatters and swishes and slaps, a ruckus of rhythmic revolution. Then they alternate, part of the time beating with me, part of the time against me, learning to say "I won't," as well as "I will." (Schoop & Mitchell, 1974, p. 120)

Now that the group's attention is fixed to an external beat, Schoop moves again into a teaching role. Her goals are, as before, the building of a flexible and varied movement repertoire along with the encouragement of self-assertion and affirmation through movement.

The Inner Fantasy

Schoop, was unique in her dedication to exploring, through dance/movement, the fantasy life of patients diagnosed as psychotic. In order to bring the patient into the world as others saw it, Schoop believed in the importance of engaging the patient through understanding and temporarily joining the patient in his/her delusions, hallucinations and ideations.

> Don't artists move easily between two worlds as they realize a flight of fancy in a poem, a symphony a sculpture, a dance? I would not want to try to stop the artist from seeing or hearing his fantastic images any more than I would want to prevent the imaginative play of a child. So I feel that rather than suppressing the fantasy of a psychotic individual, I would fly with him for a while then descend with him for a soft landing on this earth. In giving shapes to visions, he will create a world that fuses fantasy and reality. (Schoop & Mitchell, 1974, pp. 149–150)

Schoop is versatile in her methods of joining the patient in his/her world. She enters the individual's world by listening carefully, observing movement, asking questions, and translating ideas and imagery into the reality of physical expression. Once the patient's ideas are transformed into their concomitant physical form through dance improvisation and enactment, they can be worked with in many ways. They can be molded, objectified, varied, discussed, reflected upon, controlled and even mastered, at least physically. Through this process, the patient's feelings become more tangible to both the patient and the therapist. In addition, the patient has a greater feeling of control over the often frightening symbolic content of feelings when they are expressed in concrete physical form.

The example which best illustrates Schoop's style of engaging a patient through making direct contact with his delusional system is in the case study of Luke[1] (Schoop & Mitchell, 1974). The following excerpts from this case demonstrate this and other aspects of Schoop's work.

Luke was a middle-aged black man who had a peculiar movement sequence by which he greeted Schoop and others.

> It consisted of three distinct, separate actions repeated one after the other, always in the same order. To begin, he would suddenly raise both arms in a sweeping arc, which ended with his hands forming precise, devil-like horns on his forehead. Maintaining this deveilish or faun-like position, he would flatten his hands, palms turned down and, using them as if they were sharp cutting instruments, make slicing gestures along his neck. In the final movement he would drop his head on his chest and stroke his hair forward with soft, tender strokes. (Schoop & Mitchell, 1974, p. 164)

Initial contact:

> When Luke and I were seated opposite each other, and he began his talismanic mannerism, I picked it up the second time around. Carefully and precisely I made the horns, bowed, sliced at my neck, and brushed the top of my head. There was a pause. Luke's eyes were still downcast. He repeated the pattern, and again I followed it. We did it a third time. Luke raised his head. His eyes looked straight into mine. And he smiled. I smiled back. (p. 169)

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[1] These excerpts are abstracted from a 31 page case study printed in Schoop and Mitchell's (1974) book *Won't You Join the Dance?* In their book they also include a reproduction of 14 of Luke's drawings.

Early movement explorations:

> . . . Luke smiled when he came in this morning. We worked on runs, walks, skips, and turns. . . . Later, I asked him if he would like to dance to the music Erica was playing. He listened to it for a while, then selected two scarves and fluttered them about for a while. It seemed to me that the softness of the scarves might be recalling tender feelings, and that his body was reacting to them with staccato movements—like stuttering in motion. He was growing increasingly excited, so I asked him if he wanted to do his "favorite movements." He went through his pattern several times and I again accompanied him. I told him that he could feel free to do them any time he wanted to. (p. 169)

In this example, Schoop, aware of the anxiety the scarves evoked (tender feelings), chose to encourage Luke to reinstate his defensive mannerisms and remind him that whenever his thoughts or feelings made him too uncomfortable he could return to these familiar gestures.

Body-image and introduction of reality into Luke's delusional system:

> Luke was in a good mood, and smiling a lot. First we touched our own body parts in time to a rhythm. When he touched his head, or shoulder, or knees, he doesn't give the picture of touching portions of himself; he looks as if he's touching strange objects. We worked with the beaters for a while, using them to touch each other's shoulders, elbows, knees. We stood up and did a few jumps and hops. Then I held out my hands to Luke and asked him to take them so we could dance together. He looked at them for quite a while, then looked away. . . . (pp. 170–171)

Then finally, and with much hesitation, Schoop explains:

> . . . he reached out and touched my fingers—not really holding my hands, but sort of petting them in short, light tappings. He still made faces and twisted his body and peeked at me, but these reactions were less extreme than they had been the first time. We did a few more exercises. When the time was up, Luke made his usual farewell horns. I told him that in Switzerland, people usually greeted each other or said goodbye with a handshake, and I extended my hand. He took it, I gave his hand a firm clasp and released it. (p. 171)

Development of trust, many sessions later—Luke explains the meaning behind his mannerisms:

> . . . I still don't believe it! Luke came in very "normally.' He said "Good morning" without the help of his horns. He removed his shoes and socks very naturally. He sat down opposite me and immediately went through his basic mannerism several times. Then he looked straight into my eyes, and asked matter-of-factly:
>
> "Would you like to know what that means, Trudi?"
>
> "I would like that very much," I replied. "This," he said, demonstrating the bow and the horns with the index fingers extended, "is a salute to the white man. This," and he made that same first movement, this time using the pinky fingers as horns, "is the greeting of the Boy Scout, or boy. This," the cutting gesture on the neck, "is wiping away the sweat, because I work so hard. And this," and he made the head stroking movement, "means that it's a hot day."
>
> "Thank you, Luke. Thank you very much." (p. 178)

The following is a movement enactment of Luke's fantasies:

> . . . "I went to school 'til I was five. I was a girl. Then I had a mom and dad. My dad brought me a beautiful suit when I was eighteen or twenty; it had long trousers. When I went to church on Sunday, I had a dress on. I was a girl. Now I am . . . you know . . . sort of a man, or a boy."
>
> "Could you show me, Luke, or act out for me, what you did and how you moved as a girl?"
>
> "I held my left arm with my right hand. And I walked like this!" And he walked about, flouncing up and down.
>
> "Luke, you are a man now. Show me how you walk today."
>
> And Luke walked a masculine walk better than at any time before! (p. 183)

In this example Schoop first goes with the delusion, and then in her final request employs reality testing of Luke's perception of his masculinity.

In the vignette that follows, Schoop invites Luke to act out his fantasies thereby facilitating the expression and exploration of thoughts and feelings while simultaneously encouraging him in a direct symbolic interaction with her.

> . . . I asked him if he would like to act out the . . . scene with the wolf and the lamb.
>
> "Oh, yes. I want some water. I have to protect my family."
>
> I became the lamb, and Luke the wolf. I scooped up a handful of water and offered it to him. He knelt down in front of me and drank it blissfully. When his thirst was quenched, we jumped and leapt and ran about like two wolves. His movements and gestures were marvelous to watch. Finally, we lay flat on the floor on our stomachs and lapped water from the "lake". Then we changed parts and repeated the same actions, he as the lamb, and I as the wolf. After I had drunk from his hand, we hopped and skipped about like lambs, and again drank together. At last, we stood up, became erect and walked together as "ourselves". And Luke's walk was amazingly different. His step was firm and secure. His body had straightened out. It was as if he had clearly grasped the posture difference between an animal and a human. (pp. 185–186)

Here Schoop emerges as the nurturing mother who, after several months of work with Luke, is now able to engage this once severely defended patient. Then, demonstrating her flexibility in taking different roles, Schoop encourages Luke to reverse their respective wolf and lamb roles, in this way giving Luke a chance to experience metaphorically his own strength as a giving person. Finally, and not surprisingly, when they stand up and return to the reality of themselves, Luke's posture has changed. He is more "erect," "firm" and "secure" in his physical stance. These words, which Schoop used to describe Luke's physical state, seem also to reflect his emerging positive identification with his masculinity. Through the depth of rapport and trust which Schoop established with Luke, accompanied by her continual reassurance that he was okay and that she liked him, Luke was gradually able to give up his defensive mannerisms and to accept his relationship with her.

Although these excerpts from the case of Luke illustrate several aspects of Schoop's methods, they primarily point out the creative and flexible interjection of herself into the patient's psychotic process. She is willing to enter into the fantasy, symbolism, and gestures of her patients.

Finally, in discussing Schoop's use of fantasy, one must include her emphasis on the creative use of the group fantasy and group support. Schoop generally preferred working with groups. In the group she actively integrated her belief in the power of the group process with her belief in the importance of expressing the individual's and the group's fantasies.

One method of group work Schoop employed was that of having group members act as directors of their own imagination. This emerged through the group's taking on various roles, that is, becoming the cast of characters in the enactment of a drama (Wallock, 1977).

The following excerpts from *Won't You Join the Dance?* (1974) provide excellent examples of Schoop's use of the patient's imagination within the group process. In the first example, each member becomes his own director and character and the space in the room becomes the stage, or boundary for the emotional expression.

> . . . the studio becomes a huge arena, surrounded by grandstands. I choose this particular space facility because there's simply no place to hide in it; within its vast circumference, a person is completely exposed on all sides. What's more, the idea of the arena is loaded with images from which the patients can draw: the politician, the bull fighter, the fire-and-brimstone preacher, the fashion model—any person who not only wants to be looked at, but *must* be looked at. One by one, the patients walk around the ring. Here comes the "King," proudly displaying the head that wears the crown. And here is a runner, bearing aloft a flaming torch for the world to see. And this is the "General", exhibiting the medals on his puffed-out chest. Every person thus imagines a reason for showing off some part of his body. (Schoop & Mitchell, 1974, p. 132)

This excerpt again demonstrates Schoop's reliance on mime and role playing as a way to bring patients "out of hiding" and into parts of themselves previously repressed and/or fantastical.

The next case example demonstrates the way a group will frequently come together spontaneously to give emotional support and accommodation to a group member who is under extreme stress. This is the case of Alice.

> "They want to separate me from my friends on Venus," she sobbed. "They told me that's what they want to do! They said that's why they give me shock treatments!"
>
> ....
>
> "How would it be, Alice," I asked one day, "if you would tell all of us here in the group how your friends look and what they do that makes you love them so much?"
>
> "Well . . .," she began hesitantly, "they're all so happy to see me when I come up to them. And sometimes Clandestine gives me a kiss."
>
> Nobody in the group had to be told what to do. Awkwardly but with affection, they shook Alice's hand. They patted her. They smiled. Their greetings must have pleased her, because she continued her description.
>
> "They lie on golden couches . . . they drink out of golden goblets . . . they fly all around on their golden wings. They have golden dragons—very friendly ones—to play with and ride on." And Alice began to teach her willing cast how these beautiful people moved and flew and drank and played. (Schoop & Mitchell, 1974, p. 147)

The last two illustrations could be referred to as group improvisations around specific themes, the first suggested by Schoop and the latter directed by the patient's own thoughts and feelings.

Improvisation and Planned Movement Formulation

The integration of movement improvisation with planned movement formulation is unique to the Schoop (1974) dance therapy approach. Schoop compares improvisation to "doodling" with the body, that is, "a process of non-verbal free association during which the individual permits his body to move spontaneously and unguardedly" (Schoop & Mitchell, 1974, p. 143). Schoop stressed the need to follow up the subjective experience which emerges during improvisation with the ego functions of self-observation, movement production, and self-reflection. She accomplished this by helping the patient to reproduce significant aspects of his/her improvisational movement activities into planned and repeatable dance/movement sequences. In this way, the individual is helped to organize (choreograph) and thus master physically the flood of unconscious stimuli which emerges during periods of spontaneous improvisation.

> The time has come for the individual to present his subjective, free-floating feeling in an objective explicit form, with his body as the instrument for his composition. This production requires him to organize the forces of both his mind and his body. . . . As he develops a logical framework for his expression . . . he is gaining the upper hand. (Schoop & Mitchell, 1974, p. 146)

This process serves several functions. It helps in bringing previously repressed, unconscious id drives under the control of the observing ego. In this way, the individual works toward gaining the ego's control over the id, or if this ability of the ego has never developed, the

ego may be acquiring a degree of control previously out of reach. In the words of Schoop and Mitchell (1974):

> He is now able to experience that feeling without conflict, and he can communicate it accurately and realistically. Other people can recognize it. They can react to it. And their response reinforces his own reality. (p. 146)

Finally, Schoop's thoughts on the strengths and limitations of the improvisational process in dance therapy, that is, when that process is not followed by structured movement formulation, are noteworthy:

> Once a person's feelings of conflict have been brought into the body, improvisation has served its main purpose. There's no point in going on and on with it, for no matter how many times the body "admits" to a feeling, it will continue to express it in the same manner, over and over. (Schoop & Mitchell, 1974, p. 146)

Schoop believes that creative work must be done with the energy and emotions released by the improvisation. If this energy is not used to help structure insight oriented activities, the individual could become stunted in his/her growth and even become dependent on the cathartic experience, viewing it as an end in and of itself, void of internal integration, organization, and meaning.

Summary

Schoop integrates educational and exploratory approaches during the therapeutic process. She is constantly intertwining her methods in a creative, flexible, and exploratory style. The sequence reflected here—movement education, rhythm and repetition, the inner fantasy, improvisation, and planned movement formulation—appears to be more representative of her theoretical perspective than the actual sequence of her clinical work. As a result of Schoop's willingness to explore playful, expressive, and creative interactions with her patients, she contributed many unique dance therapy techniques.

6

Alma Hawkins

Alma Hawkins was chairperson of the Dance Department at the University of California, Los Angeles from 1953 to 1974. In 1963, she introduced dance therapy to U.C.L.A., and her work there evolved into a comprehensive dance therapy program. Today, the Master's Degree program at U.C.L.A. is directed by Erma Dosamantes-Alperson.

Hawkins started her career in dance therapy in the early 1960's while working with Alfred Cannon, a psychiatrist at the Neuropsychiatric Institute at U.C.L.A. The two worked together with individuals and groups, and with both adults and children. Hawkins worked at the Institute until 1977.

Hawkins studied dance extensively in the 1930's and 1940's with modern dance innovators such as Doris Humphrey and Hanya Holm (A Wigman disciple) at Bennington College in Vermont. Though she has studied with professional artists in dance, the emphasis of her work has always been primarily in education.

Marcia Leventhal[1] says that Hawkins "helped to put dance on the map in California." (1987, p.c.) Leventhal continues:

> She has always been a totally committed, and knowledgeable advocate of dance, and because of her very respected position and the kind of stature and aura she carried at U.C.L.A., people with authority listened—taking dance into the mainstream and out of second class citizenry. (Leventhal, 1987, p.c.)

In her advanced study, Hawkins was deeply influenced by the work of Harold Rugg, professor at Columbia University Teachers College in New York. Rugg was interested in the nature of creativity as it relates to all the arts. He believed that movement played a fundamental role in the arts and was an integral part of the thought process (Hawkins, 1985, p.c.).

While teaching at U.C.L.A., Hawkins sought to increase her understanding of the nature of the creative process and the fully-functioning person through the writings of and personal study with people such as Edmund Jacobson (relaxation), Robert Ornstein (modes of consciousness), and Eugene Gendlin (inner sensing). She worked with Valerie Hunt and they frequently discussed their common interest in movement. She also spent many hours discussing dance therapy with Mary Whitehouse, a long-time friend who taught dance therapy at U.C.L.A. for one year. Hawkins said:

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[1] **Leventhal, a protege of Hawkins, was the first student intern who conducted sessions, directed research, and assisted Hawkins from 1963 to 1965.**

> Mary Whitehouse and I shared many ideas. We did have much in common and I think a little of each of us rubbed off on the other. Our basic ideas were the same, but the approach sometimes differed. (1985, p.c.)

Alma Hawkins' career has gone full circle—first working with dance, then developing a dance therapy program, and now again teaching dance. She is currently teaching the fundamentals of choreography at Santa Monica College in Los Angeles. The course attracts artists, dance majors, and leaders in therapy (Leventhal, 1984). Hawkins has influenced several leading dance therapists, including Marcia Leventhal, and Erma Dosamantes-Alperson, Susan Lovell, and Joanne Weisbrod.

Theory

Leventhal, an associate professor and director of the Master's degree program in dance therapy at New York University, remembers her early training with Hawkins in the 1960's. She states:

> . . . we always returned to the basic premise of Dr. Hawkins: that there is an inherent talent and creativity residing within each individual, waiting only to be guided and untapped. She has dedicated her life to the art of dance with the belief that there is no swifter, truer way for an individual to reach his/her fullest growth potential. (Leventhal, 1984, p. 7)

Hawkins feels that people today are searching for a way to integrate mind and body, which have been separated in our culture for too long. The body self must be strong before we can see ourselves and relate in the larger sense: "We can't deal very well with the environment until there is a secure sense of self as an anchor" (Wallock, 1977, p. 96). Through the movement process, the individual can get in touch with his/her own feelings and thus be able to interact more meaningfully with the environment.

Hawkins views the components of movement as energy, space, and time. Like many of the other pioneers, she works with "polarities"—extremes and ranges of these three components, such as big/small, strong/weak—and with shades of polarities. This leads to flexibility of range and patterning, which set an optimal mode for perception and experience. She states:

> . . . what I am trying to do is not *dancing;* rather we are stripping the experience down to the purest approach to movement. . . . The more I work, the more I see that movement and the body are related to perception. (Wallock, 1977, p. 90)

In this connection, Hawkins believes that relaxation is a highly significant factor affecting perception. She has incorporated into her work the research of Edmund Jacobson concerning residual tension. Jacobson emphasizes the need to identify and control tension in order to reduce anxiety, build body image, and increase perception. A high degree of residual tension not only increases anxiety but also blocks perception. This results in a narrow, rigid pattern of response, which keeps one from his or her own creative influences. According to Hawkins, "an optimal mode of handling information and functioning is being open to a wide range of sensory data . . ." (Wallock, 1977, p. 90).

The person who has achieved a state of relaxation is better able to discover and release their creativity and natural energy flow—"authentic movement." Getting in touch with various levels of consciousness, he/she can then respond with more spontaneity and imagination. Energy flow and movement pattern thus become truly "authentic."

Authenticity in movement, according to Hawkins, implies that the externalized movement pattern is congruent with inner sensing (p.c., 1985). Through relaxation, one opens the threshold to inner sensing (i.e., attentiveness to the inner self) and makes possible a new connection with previous experiences and memory traces. The movement that develops from this state can be filled with meaning and insight. Based on the work of Ornstein (1972), Hawkins sees this as involving the right hemisphere of the brain, and makes possible "an inner way of knowing, the intuitive, holistic sense rather than the linear, sequential way of experiencing and knowing" (Wallock, 1977, p. 81). From this evolves "body-self"—the "ground structure for body image, body ego, body boundary . . ." (Wallock, 1977, p. 91).

Hawkins, in an interview with Susan Wallock (1977), described her own theoretical model as a "growth model" (p. 92), and specified humanistic psychology as one of the many influences on her work. In an interview with Leventhal, Hawkins shared her thoughts on the relationship between dance as an art form and dance as a tool for healing. She stated:

Alma Hawkins in her California studio, 1987. (Photo courtesy Mark Harmel.)

> . . . there is a basic movement process that can be directed toward therapeutic goals. It is this process that brings about the change. This basic movement process is in reality a creative process which can just as easily be directed toward an aesthetic goal and the achieving of an art object. It seems to me that in both art exploration and in dance/movement therapy the basic process is the same. (Leventhal, 1984, p. 9)

Hawkins believes that as long as the creative process is based on "inner sensing, feeling and imagery, healing will occur" (Leventhal, 1984, p. 10). "Man seeks creative and aesthetic experiences because they enrich him . . . help him become an integrated individual and help him feel in harmony with his world" (Hawkins, 1972).

Methodology

Hawkins sees her role as a dance therapist as a facilitator or guide rather than as a teacher or director. Her goal is to catalyze creative experiences that work toward putting individuals in touch with their thoughts and feelings, thus making it possible for them to more fully respond to internal and external stimuli. In the following quote, she describes the development of her methodology.

> . . . through the experience of trying not to use things related to dance technique. . . I acquired a clearer understanding of the basic movement phenomenon. Eventually, I began facilitating movement events using the elements of movement: time, space, energy flow. I always allowed the experience to be directed or cued from what the patients were giving. Even though I knew enough not to teach dance or to do prescribed exercises, it took me a while to discover the true nature of basic movement. (Leventhal, 1984, p. 8)

Whether it be verbally or nonverbally, Hawkins supports whatever experience the individual is having in the session and suspends judgment. She may facilitate the verbal discussion of movement experience by asking the individual questions such as, "Did you feel anything different happening today in the way that you were moving . . .?" (Leventhal, 1984, p. 11). She does not believe in telling the individual what she saw in their movements or describing to them how they moved. Similarly, she does not interpret the client's movement response but will support their revelations as they occur, believing that growth happens in time with the client setting the pace for his/her own insights. Hawkins' challenging role as the therapist is discovering the kind of experiences that best support the individual in his/her journey toward self-realization.

Hawkins usually starts a session with guided movement experiences that help to focus attention and broaden experiencing. Then she turns to relaxation, which is followed by attending to breathing. During the remainder of the session, individuals are involved in movement tasks that are motivated by imagery. The images are always open-ended and allow for self-directed response. Sessions frequently include experiences that allow two individuals or a group to interact in response to an image and explore a movement idea together. Hawkins sees imagery as a developmental experience, ranging from concrete to abstract.

Imagery is an integral aspect of Hawkins' work. She describes her use of it as follows:

> I began exploring the use of imagery in dance classes in the early 1960s. Then when I started working with dance therapy I experimented with a wider range of imagery—

> personal, concrete, abstract. And in recent work I have worked in greater depth, especially in the use of imagery as a means of facilitating "inner sensing" and the creative process. (1985 p.c.)

Hawkins also works with self-directed responses and "felt-level" experiences. The latter she describes as experiences "derived from 'inner sensing,' which are different from pure emotion" (1985, p.c.) in that they are purely bodily-felt experiences and perceptions put into movement. At the close of a session, the group comes together to share their experiences.

Summary

Hawkins' contributions as a therapist, artist, and educator have influenced dance therapists, choreographers, dancers, actors, and movement educators. Her major contribution has been in the area of integrating imagery and the elements of dance and creativity into a formal healing experience based on the tenets of humanistic psychology.

Discussion

Similarities and Differences Among the Major Pioneers

The contributions of six pioneering leaders during the 1940's and 1950's set a firm foundation for the practice of dance therapy today. By the early 1960's, the practice of dance therapy 1) had already serviced a broad spectrum of emotional disorders, and 2) had utilized an equally broad range of practical interventions and facilitating techniques.

However, areas which were still underdeveloped at that time were empirical research, experimental research, and the establishment of a complete theoretical framework which would serve to integrate the field's broad spectrum of theory and practice. Though theoretical foundations were established by these leaders and through their reliance on pre-existing frameworks such as the works of Freud, Jung, Adler, Reich, and Sullivan, the actual integration was still somewhat sparse and was more often discovered through verbal exchanges with these pioneers rather than in their writings. The fact that the theory of dance therapy seems to have developed more slowly than its practice is perhaps in keeping with the nature of the dancer/therapist as essentially being an action-oriented individual who aesthetically "feels" his/her way to the needs and realities of others, intuitively adapting to these needs, both verbally and non-verbally.

The similarities and differences among the original pioneering leaders in dance therapy can be explored in terms of: 1) the style of intervention (verbal versus non-verbal facilitation); 2) the degree of therapist control (directive versus non-directive approach); and 3) the predominant emphasis or focus of the therapist's attention (horizontal vs. vertical process—Siroka, 1976, p.c., or, individual process vs. group process).

Style of Intervention

During the 1940's and 1950's, two distinct styles of dance therapy intervention existed. The first has been called the Therapeutic Movement Relationship, and is characterized by the dance therapist's combined verbal and non-verbal participation in and facilitation of movement. The second is the empathic observer role, characterized by the primarily verbal facilitation of movement while the dance therapist quietly observes. While these styles of movement elicitation differ, the movement forms patients arrive at (mime, dramatic movement, improvisation, and other styles of symbolic movement expression) frequently overlap. This overlap in movement form, but contrast in intervention or elicitation style, is demonstrated in the diversity of the major pioneers. Chace utilized the therapeutic movement interaction as a major vehicle by which she elicited these forms. Hawkins arrived at similar movement forms but did this through encouraging the patient's imagination and suggesting creative movement ideas. Patients of Whitehouse and Evan also came to these movement forms, although these dance therapists stressed free association through body movement, in addition to encouraging patients to enact images and dreams. Hence, while similar movement forms might evolve, the way in which these forms were catalyzed varied tremendously.

Degree of Therapist Control

The degree of therapist control ranges from the therapist allowing the patient to be self-directing to the therapist being in total control. All of the major pioneers were sometimes directive—teaching movement, structuring body awareness exercises, suggesting movement themes, and/or choreographing.

Chace, through movement interaction, encouraged rhythmic expression. This expression, in conjunction with the therapeutic movement relationship, guided the individuals in their struggle for self expression. Because Chace was always part of the patient's movement experience—guiding, narrating, and reflecting—a large degree of therapist control was always present. On the other hand, Whitehouse and Evan sat to the side while their people improvised. They directed by helping individuals to formulate movement explorations, often around suggested or emergent themes. However, once the patient was involved in an improvisation, he/she was given independent time and space to explore conscious and unconscious thoughts and feelings. Reflection and discussion took place after the movement sequence came to its natural conclusion. Both Whitehouse and Evan spoke of the natural or inevitable ending of the patient's improvisation. The implication here is that the dance therapist allowed the improvisation to take its full course without interruption or direction.

Schoop, like Chace, took a more directive role. Both Schoop and Chace worked with hospitalized psychotic patients and both tended to stay more in the moment, as opposed to delving into unconscious material. In addition, Schoop encouraged the choreographing of emotions to help patients cope in their day to day lives. Espenak, on the other hand, moved freely back and forth between directive and non-directive roles. She worked both in hospitalized settings and in private practice.

The pioneering leaders all took active control of dance therapy sessions, though in different degrees and through individual styles. All of the pioneers offered, either verbally or nonverbally, thematic and projective material for patients to explore. At no time were patients left to explore movement on their own without some kind of initial directive, ongoing guidance and narration, reassurance, and/or reflection.

A pattern emerges amongst the pioneers. Those who worked with the more severely disturbed hospitalized patients tended to stay in the here and now, focusing more on conscious thoughts and feelings with a greater stress on patient/therapist interactions. Those who practiced privately with a healthier patient group delved more into the unconscious and early childhood material. In addition, they allowed for in-depth individual improvisation.

Major Focus of Therapist's Attention

The predominant emphasis or focus of the therapist's attention can be discussed in terms of the concept of "horizontal" versus "vertical" stress (Siroka, 1976, p.c.). "Horizontal" here refers to the process often seen in group psychotherapy whereby a specific or immediate theme of one individual is generalized or broadened so that it is applicable to one more general needs of the group. In this way, what emerges is a continual process of mediating between the needs of the individual and the needs of the group. One example of the horizontal approach is Schoop's use of teaching patients many different movement styles. Through this educational approach, they can learn about themselves, others, and about the overall possibilities of personality and behavior styles from which they can discover different aspects of themselves.

The vertical approach, on the other hand, delves more deeply into psychic conflicts and developmental needs of one individual, whether it be within a group or in a one-to-one format. The word "vertical" is used to indicate delving deeply into the personality of one individual, as is seen regularly in the work of Whitehouse, Evan, Espenak, and at times in Schoop (most notably in her stress on the movement fantasy).

It is important to emphasize that the horizontal and vertical models can be used in either individual or group sessions. For example, though some dance therapists, like Evan, worked in both individual and group sessions, Evan tended to emphasize the individual, using the vertical process in both settings. Chace, though unique in her ability to reach deeply into the emotional life of her patients, worked primarily as a group dance therapist with a horizontal focus; that is, she moved with the emotional needs of as many group members as possible by mediating quickly and intuitively between these needs and modifying movement patterns to connect with the majority of group members. Chace fluctuated rapidly between group and individual needs, dipping into the individual process just long enough to establish contact, and then reuniting the individual, through his/her movement, back into the group process. Chace also used the needs of the individual to deepen the group process, thus creating a reciprocal horizontal process.

Summary

While there are overlaps in the kinds of movements that are elicited, the method of elicitation distinguishes one dance therapist's style of intervention from another. In the area of control, all six major dance therapy pioneers exerted direction, but some emphasize verbal direction and others physical. Some dance therapists' major focus is on deep individual intra-psychic exploration, while others continually negotiate between individual and group needs, always bringing the emphasis back to the group's level of emotional expression.

SECTION C

Other Early Leaders, Pioneers, and Contributors

7

Dance Therapy Emerges In the Midwest

As noted earlier, the pioneers in dance therapy very often studied with creative and modern dance instructors, and then expanded this knowledge to develop the concepts of dance therapy, that is, dance as a psychotherapeutic tool. Many of the early dance therapists in the Midwest were greatly influenced by Margaret H'Doubler, a "landmark dance educator" (Thomas, 1986, p.c.). Though not a dancer herself, H'Doubler fought for the inclusion of dance as an academic discipline in universities across the country. She began to teach dance at the University of Wisconsin in 1918 and retired in 1953. Published in 1940, her text, *Dance: A Creative Art Experience*, remains a classic today. Her teachings are still having an impact on the field; seven respondents to a 1984 survey (see Unit III A) listed H'Doubler as influential to their dance therapy work.

Although H'Doubler did not practice or show an interest in dance as a form of therapy, her beliefs about movement led her students naturally into an exploration of dance therapy. She felt that "the outer movement expression of inner feeling states and emotions acted as a means of keeping and restoring emotional balance" (Rose, 1950, p. 51). By the early 1950's there was a growing interest at the University of Wisconsin in dance and movement education as a process for dance therapy, on the part of H'Doubler's students, notably Rhoda Winter Russell, and H'Doubler's colleagues Shirley Genther and Maja Schade. H'Doubler contributed to this trend, supporting student and faculty research in the area.

Utilizing humanistic educational philosophies of men like Dewey (Thomas, 1987, p.c.), H'Doubler taught "from the inside out," beginning with the person's sensation and perception of the movement, rather than "from the outside in," beginning with an external style and form. Her students were required to investigate music, rhythmic form, anatomy, physiology, physics, kinesiology, advanced biology, and physical education theory as part of their dance curriculum (Russell, 1986, p.c.).

H'Doubler's view of movement is reflected in the following statement by Russell:

> She aimed . . . to develop kinesthetic awareness, perception, and the ability to give adequate motor response; to discover and evaluate feeling states that accompany movement sensations; to experience the expressive power of movement; to gain the understanding that meaning and communication are due to the structure of the movement form. (Russell, 1970, p. 69)

An example of H'Doubler in action is provided by Deborah Thomas, a leading dance therapist who did graduate work at the University of Wisconsin, and became the director of Wisconsin's undergraduate dance therapy program. Thomas describes a class H'Doubler led in 1976, in celebration of the 50th anniversary of the Dance Major at the University of Wisconsin.

> . . . she was asking the seated students to pay attention to the location and movement range of their shoulder blades (. . . with the aid of a skeleton . . .). This felt very pleasurable and "new". Then she asked us to hold our arms extended straight forward from the shoulder while continuing exploratory movements of the shoulder blades. Later she added a lifted head with the gaze straight up. She then got the whole group walking more and more swiftly in this configuration across the whole length of the large gym, until they were running. It was an ecstatic flow of movement, built from inner exploration. It illustrated her technique of adding one element at a time for greater ease of perception (and coordination), and her practice of building from the student's own kinesthetic awareness rather than an external image. The resulting movement structure emerged "naturally" with a great sense of discovery and beauty. (Thomas, 1986, p.c.)

One can see from the quote above how H'Doubler's teachings could inspire her students to explore the use of dance as a form of therapy. In addition, says Thomas:

> At 80 she was a vivid, vitally interested person—she was interested in you! Her eyes and facial expression told you that you were special—and full of potential. She was looking for what would strike you—for signs of how you were going to interact with a particular idea. Her enthusiastic attitude was infectious and helped one overcome self critical hesitancies (1987, p.c.)

By the early 1950's, dance therapy was becoming a focus of attention and activity at the University of Wisconsin. Shirley Genther, a well-respected musician who was teaching music and rhythmic form and analysis, developed a special interest in psychodrama and the expressive therapies. She was one of the major forces behind the development of movement therapy at Mendota State Hospital, where several University of Wisconsin students did internships in dance therapy.

Genther, in collaboration with psychiatrists Thelma Hruza (1954), and later Edna Fitch, studied the use of creative dance with psychiatric patients. In preliminary sessions at the University of Wisconsin, they experimented with the combined use of dance movement and psychodramatic methods. Then, under the supervision of a staff psychiatrist at Mendota State Hospital, their methods were introduced to a group of severely disturbed patients. After doing relaxation exercises and simple body movements such as swings, and discussing how the movements felt, the patients began to feel more comfortable with their bodies. As this comfort increased, "movement drama" was introduced to "reinforce and sometimes replace psychodrama" (Genther, 1954, in Rosen, 1956, p. 78). This concept of the movement drama reappears again in the late 1970's under the heading of "Psychodramatic Movement Therapy" (Levy, 1979).

Rhoda Winter Russell, a disciple of H'Doubler and a pioneer in dance therapy, was the first University of Wisconsin student to receive dance therapy training at Mendota State University Hospital (1951–54) and go on to develop and use those principles and techniques in psychiatric settings. Her studies in this area were supervised by Shirley Genther, and her Master's thesis, "Motion and Emotion: The Choreography of Feelings" (University of Wisconsin, 1954), was supervised by H'Doubler.

H'Doubler's explorations of kinesthetic awareness and the connections between movement and human expression laid a foundation upon which Russell could work. Later, Russell travelled to Germany to study with Wigman. In her subsequent dance therapy practice and teaching, Russell integrated the pragmatic, unstylized approaches of H'Doubler, Wigman, and later Alwin Nikolais to help clients "become fully themselves in movement" (Russell, 1986, p.c.). From this training and other influences, including Rational Emotive Therapy, Gestalt Therapy, and Humanistic Psychology, she developed her own dance therapy methodology and initiated her own dance therapy training programs in New York City and Philadelphia. By 1956 she was in New York practicing as a movement therapist at Manhattan State Hospital and in private practice. It is interesting to note that among her trainees was Miriam Berger, a former Vice President of the ADTA who has become a major leader in the field. Berger's work reflects the influence of Russell as well as Marian Chace, with whom she also trained.

Maja Schade, a dancer, dance instructor, and physical education teacher, was also at the University of Wisconsin during the early 1950's. Like Russell, Schade was influenced by the teachings of H'Doubler, and also paid tribute to the ideas of Delsarte, Laban, Mensendieck and Ernst Kephart. At that time, she was becoming involved in the use of movement and relaxation as a healing tool. Her relaxation techniques, based on Jacobson's (1929) *Progressive Relaxation*, were described by Joanna Harris (1980), one of her former students, in terms of reassessing one's energy patterns and the use of mind/body imagery. Schade was also known for her work in physical correctives, particularly her use of structured therapeutic movement exercises.

It was also in the 1950's that Schade began teaching dance therapy in undergraduate courses at the University of Wisconsin. As part of their coursework, students were brought to psychiatric hospitals to work with patients (Kuppers, 1980). In addition, Schade helped to organize the first ADTA conference held at the University of Wisconsin in 1968.

Joanna Harris was a student of Schade, Genther, and H'Doubler. Their influence, along with that of Mary Whitehouse, Merce Cunningham, and developmental, Jungian, and psychoanalytical psychologies, laid the foundation for Harris' work in dance therapy.

Although the University of Wisconsin was an important center for early dance therapy leaders in the 1950s, it was not the only source from which dance therapy in the Midwest took root. Other important leaders and contributors were experimenting independently during these formative years, notably, Alice Bovard-Taylor (Minnesota) with psychiatric patients, Billie Logan (Minnesota) with retarded children, and Norma Canner (Ohio) with psychiatric and cerebral palsy patients. Some of these important leaders and their work will be discussed further in later sections of this text.

8 Pioneering Literary Contributions to Dance Therapy

This chapter discusses two pioneering literary contributions to dance therapy and outlines one of the first important studies analyzing the discipline.

First, Franziska Boas' (1941) article "Creative Dance" is reviewed in detail. Boas' article was the first comprehensive discussion of dance therapy techniques with children, and is still referred to today.

Also summarized here is Elizabeth Rosen's book, *Dance in Psychotherapy* (1957). Although (unfortunately) now out of print, few books today can compare to this detailed account of dance therapy with the hospitalized psychiatric population.

Finally, the 1956 study reviewed in this chapter analyzes the development of dance therapy at this early stage in its history. The study serves as a useful benchmark in reviewing the course of dance therapy through the years, and how that course affects the state of the art today.

Franziska Boas (1940's)

Franziska Boas contributed two seminal articles to the literature of dance therapy in 1941. She later consolidated both articles into a comprehensive chapter for Lauretta Bender's (1952) book, *Child Psychiatric Techniques*. This consolidated article, entitled "Creative Dance," was reproduced in Costonis' 1978 book, *Therapy in Motion*. Through this publication, Boas' work remains influential today.

The ideas Boas expressed in "Creative Dance" were clearly part of the whole climate of dance therapy theory and practice of which she was a part. In the 1940's, Boas was practicing dance as a therapeutic modality at Bellevue Hospital in New York. It was during this time that psychoanalytic thought, which was gaining widespread acceptance, merged with the concept of the "inner dance," which was prevalent in the first part of the century. Boas, influenced partially by this changing environment, integrated psychological concepts and therapeutic goals into her movement work at Bellevue.

It should be noted, however, that Boas was not primarily a dance therapist, but rather a teacher of creative modern dance. She was deeply influenced by her father, Franz Boas, the anthropologist. At the Sixth Annual Conference of the American Dance Therapy Association in 1971, Boas spoke about the relationship between dance-as-art and dance-as-therapy. The ideas she expressed at that time reveal a definite drift to her original roots in dance, without the accompanying psychoanalytic terminology that was present in her articles. Clearly, Boas is first and foremost a dancer, teacher, and researcher.

Boas attributes the development of her approach partially to her dance studies with Bird Larson (who also influenced Blanche Evan) and partially to her studies with Hanya Holm (Boas, 1987, p.c.). She was also greatly influenced by the work of Mary Wigman. Gradually, Boas evolved her own teaching styles in which she integrated technical movement skills with creative movement in a style she calls creative modern dance. She postulates that this creative and expressive approach to dance is inherently therapeutic.

> I make no separation between dance as an art and dance as a therapy. Every art has a therapeutic effect both on the artist and on the observer. It depends entirely on how you look at it; why you are dancing or painting or writing, etc.; why you are asking someone to take part in the activity. These things will determine whether the activity is for therapeutic purposes or not. Dance can be both therapy and art. (Boas, 1971, p. 26)

The philosophy which Boas discussed looked at the function of dance in life and reflected her belief in dance as the expression of the human spirit.

> . . . dance happens for its own sake. The movements become symbols of tensions, feeling and inner thoughts. To dance one must sense changes in weight, velocity, tensions and volume. One must be able to feel large and small space, dense and open space. One must be willing to allow the laws of motion to control the body and carry it where they will. . . . This requires the courage to "lose oneself" in the happenings which are going on within the body and mind. Mary Wigman has said, "One cannot dance without having encountered the spirit." (1971, p. 22)

Dance, Boas asserts, has an innate power—a dynamic force which, if allowed, moves through the body and reveals the thoughts, feelings, and the spirit of the dancer. This connection of dance to the spiritual aspects of man lifts certain aspects of dance therapy out of the realm of the sciences and reunites it, in part, with the arts. This concept is especially important to today's dance therapy. Many pioneering and contemporary leaders in the field are urging students to go back to dance in order to find the essence of dance therapy (results of 1985 survey; Evan, 1980, p.c.; White, 1986, p.c.). There is deep concern expressed among these leaders that the newer generations of dance therapists are relying too heavily on the "vision" of other disciplines (e.g., psychoanalysis, bioenergetics, etc.), forgetting, or perhaps never having truly understood and concretized for themselves, the inherent healing power of dance itself.

"Creative Dance"

In her article "Creative Dance," Boas' approach is articulated primarily within the context of her experiences at Bellevue Hospital working with children, and in her studio work with dancers. At Bellevue, Boas incorporated into her creative dance techniques ideas and methods which grew mainly out of her association with Lauretta Bender and Paul Schilder.[1]

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[1] Lauretta Bender, a psychiatrist, is the author of *Child Psychiatric Techniques* (1952). Paul Schilder, a psychiatrist and psychoanalyst, is known for his classic work, *The Image and Appearance of the Human Body* (1950).

Franziska Boas. (Photo courtesy Boas and D'ter.)

Boas was greatly influenced by Schilder's belief that the individual's movement behavior was the direct expression of his/her body image. She gives an example of a schizophrenic boy who wanted to try a backward somersault. Each time he tried, he stopped short for fear he would die or lose himself. This exemplifies how an inadequate, fragmented, or incomplete body schema (Schilder, 1950) can limit and define the parameters of self-expression available to the disturbed individual.

With Schilder's support, Boas stressed that just as the body image affects the movement repertoire, so deliberate changes in this repertoire can affect and develop the body image. This theory is basic to Boas' work. For this reason, she placed greatest emphasis on encouraging a variety of movement experiences. This meant, for example, subjecting individuals to new postures and extensive exploration of movement activities which brought the body close to the floor (e.g., lying down, using all fours, etc.); having individuals work with eyes closed; and using percussive sounds as a vehicle for encouraging movement responses. She postulated that the provision of new movement experiences external to an individual's usual preferences facilitated an awareness of self and an ability to explore dimensions of personality otherwise not available. For example, she used the floor a great deal, believing that floor work encouraged the awareness and instinctual coordination of the animal or primitive in man.

> Everything which disturbs or changes the relation of the individual to the vertical plane (gravitation) affects the motor mechanism of the entire body. The whole system of postures is fundamentally different when an individual is lying on the ground, or when he is standing. Even when he is standing upright the muscle tone is very different according to whether the head is turned forward or to the side. The whole distribution of tone changes with every change of position of the head. (Boas, 1978, p. 115)

Boas believed that human beings, as part of a civilized culture, continually struggle with unsatisfied primitive and chaotic impulses. She emphasized the importance of allowing children to experiment freely and indulge in chaotic and formless expression before attempting to shape, form, and structure their creative movement experience. She believed that it is the satiation of these early primitive impulses toward freedom that enables children to eventually develop their own integrated movement styles. That is, the sublimated expression through movement and dance of thoughts, feelings, and fantasies evolves in a spontaneous and natural way, rather than in a rigid or stylized fashion.

> This [early] type of investigation and learning should be allowed to continue to the point of saturation, then the disorganized movements and chaotic themes begin to form themselves into rhythmic repetitions and recognizable fantasies. In other words, the primitive animal-like impulses may furnish material for sublimation into an art expression. (Boas, 1978, p. 118)

The role of the "teacher-therapist" is to be sensitive to the student's readiness to move beyond this early stage, to a stage which Boas called "subconscious sublimation" (1978, p. 118). Subconscious sublimation is a more organized and symbolic level of motility. Boas pointed out that not all children will be able to make this transition. When sublimation is blocked, two behavior patterns may occur. The first is the individual's retaining a chaotic infantile style of movement; the second is the adaptation of movements for escape in defense against natural primitive desires.

Boas believed that the greatest obstacle to psychophysical integration is the fear of experiencing the self in a new and different light. This is often expressed as a fear of falling, loss of control, or loss of a body part.

> The feeling of his own physical strength and the ability to control and direct it is a stage the dancer reaches after having freed himself from anxiety and fear over the dynamic violence of primitive motility and its associated emotions. For the dancer, anxiety and fear of dynamic movement spring from insecurity in the concept of his own body image and from the resistance to consecutive changes in himself. Exploration of the dynamic power of movement brings to the fore instincts of self-preservation, destructive and constructive drives, and through their mastery brings about an understanding of these elements. (Boas, 1978, p. 130)

The major part of Boas' work was dedicated to helping children and adults experience, through dance movement, these "unconventional" aspects of personality. In order to free muscular rigidities, she devised many techniques which allowed individuals to explore diverse movement styles and still remain in control. She provided movement ideas, themes, and situations which gave individuals permission to relax the usual controls of the ego and superego, and encouraged the controlled use of physical regression for the purpose of self-discovery.

Projective Technique

During the 1940's, Boas and Bender were synergizing their efforts in the study of projective technique at Bellevue Hospital with Margaret Naumberg in art therapy and Adolf Wollman in puppetry. Other pioneers of this technique were Sidney Levy, who specialized in the study of symbolism in animal drawing, Karen Machover, who specialized in figure drawing as a projective technique, and Henry Murray, who developed the Thematic Apperception Test. The seminal thinking in projective techniques that evolved at this time enriched Boas' already developed style. The use of animal projections, role playing, and story telling were an integral part of Boas' dance/movement work.

Boas believed in, and actively utilized, dance as a form of expression of affective and cognitive processes. She stressed that dance is more than the physical or mechanical action of muscles and joints, but is also the expression of the individual's subjective concept of his/her body. In her work, she combined the active use of movement in the form not only of dance, but also of drama and role playing, with the verbalization of fantasies. The use of dramatic play as a tool for the projection of one's thoughts and feelings onto external objects and ideas is demonstrated in the following excerpt from Boas' work.

> . . . Several children began to ride on the teacher's back. Carrol . . . played at being a buffalo and butted the children and the teacher. Then he tried to make a double animal by putting his arms around the waist of a crawling boy and crawling behind him.
>
> Benjamin was a chicken attacking children. The chicken was killed by a child; it came alive and was killed again. Finally it was really "dead" and should be buried. The children "dug" a grave and "covered" him up. They all wanted to step on the "grave" and then left him. Carrol did not take part until Benjamin was buried. Then he crouched next to him,

> closed his eyes and performed a kind of sorceror's dance. He had a slight vibration in his body and passed his hands back and forth over Benjamin's head and body. When the children came back he pushed them away. (1978, pp. 126–127)

Boas encouraged the development of an animal activity by positioning children supine on the floor and asking them to explore different movement activities from this position.

> From these exercises the usual development is into animal fantasies with their characteristic movements of crawling on all fours, propelling the body across the floor without the use of hands or feet, rolling over one another, jumping like frogs. Certain children prefer to retain their human character. This leads to dramatic dance games of shooting animals or of animals attacking humans, or horse and rider games. (1978, p. 128)

Boas indicated how the development of one child climbing on another can often lead to other kinds of movement activities and fantasies, such as

> . . . diving into water and swimming, animals jumping from trees onto and over objects and each other. . . . These are soon combined with more complicated rhythms such as cartwheels and somersaults remembered from the work on the floor. (1978, p. 129)

One can see in Boas' work her tendency toward dramatic movements, role playing, and the active use of the child's imagination. She combined play activities and story telling with a concentration on the growth of movement skills, and simultaneously integrated the movement fantasies that these play activities provoked. Her stress was twofold: improved motility, integrated with the acknowledgement, acceptance, and development of the concomitant psychic fantasies.

Boas' use of dramatic play demonstrates the emphasis she placed on pure expression. She did not speak in terms of analysis and interpretation. In fact, she was deeply concerned that premature analysis or interpretation could stifle the creative and expressive process (1978).

Use of Music and Sound

The use of music and sound was an essential aspect of Boas' work with children. Like Evan, she used musical instruments extensively.

> Recognizable rhythmic and dynamic [movement] patterns grow out of tension in the individual and tensions in the group. . . . Most of these patterns demand externalization in sound. Some require a rhythmic drumbeat, others a mellow gong tone or a sharp cymbal crash. A musical accompaniment . . . [has] to be created. . . . Sounds fill space with substance. (1978, p. 121)

Boas explained that the use of percussion in the background can act as an auditory guide to provoke certain actions and reactions as well as to reinforce emerging patterns of mobility. Like Chace, she used repetition as a way to impel the development and expression of new and dynamic movement patterns. She speculated that the sensory impression of the percussive beat may have a deep psychological influence. Furthermore, rhythmic sound tends to invite even the most resistant children into participation and often acts as a safety guard for feelings. That is, feelings are expressed within auditory guidelines or sound boundaries. This helps put a lid on expressions of, for example, hostility, which otherwise may surface out of control. The repetition of sound adds a sense of play or unreality, thus creating an atmosphere in which it is safe to express oneself.

Boas emphasized that by playing percussive instruments, the therapist could help to direct the flow of the emotional expression through the use of crescendos, accelerandos, retardandos, and diminuendos.

> The sounds emerging from percussion instruments in themselves have specific qualities which relate to space, time, and tension. The drum bounces its listeners in space and creates a desire for rhythmic action. The cymbal softly played cuts space and spreads out in all directions horizontally. The gong fills space and suspends the hearer in it. Sharp sounds produce strong tension and penetrate space. Soft sounds produce weak tension and fill space. Regularly reproduced sounds produce repetition of movement and activate space. Crescendos produce increase in tension and fill space with activity. Descrescendos decrease tension and quiet the space. Accelerandos increase speed of movement and activate space. Retardandos decrease speed of movement and empty space of action. (1978, p. 121)

In summary, Boas used music and sound as structure to expedite several major aspects of the therapeutic process. These include: focusing encouraged by rhythmic repetition; control and guidance of self-expression; broadened use of movement; and release of vocal expression with dance action.

Boas, shown here with her students, is known for her innovative use of percussion instruments. (Photo courtesy Gertrude Michelson and Franziska Boas.)

Movement Improvisation or Psychomotor Free Association

A technique that Boas used in her private studio work as a dance teacher and which is used widely today is that of psychomotor free association during dance, a technique similar to Whitehouse's active imagination. Like Whitehouse, Boas often initiated this by having students work with closed eyes while moving spontaneously to sustained gong tones or in silence. Most students began with self-conscious and/or frustrated movements, such as adjusting hair and clothes or collapsing, stamping feet, and so on, but were then encouraged to go beyond these reactions. Boas urged them to enact the movement as soon as the thought or impulse appeared, thereby establishing a free and constant flow of information from mind to body.

During this process, Boas stated,

> . . . gradually more and more movement is experienced and larger gestures are made. The body begins to respond to the various shifts of weight and begins to travel through different space levels following the laws of inertia, impulse, and momentum. Emotional reactions become manifest and changes in tension begin to create a dynamic and rhythmic flow of movement. During these activities the instructor is constantly encouraging by words and sounds the externalization of gestures and movements which begin to make their appearance. Eventually only the percussion sounds are continued, and the body moves by itself. (1978, p. 132)

She continued:

> There is a logic in the development of one movement into another both in the body and in the use of space. To the trained observer any interjection of an arbitrary movement can immediately be discerned. This is a sign of a break in concentration and usually takes the form of some habit movement pattern which the pupil considers "safe," that is, either it covers up the externalization of a "forbidden" fantasy or sensation, or it prevents exploration into the unknown. (1978, pp. 133)

This style of work grew directly out of the modern dance movement championed by Mary Wigman during the early part of this century. Boas, in her 1971 ADTA presentation, referred to Wigman and to Wigman's disciple Hanya Holm (Sorell, 1969) concerning their delineation between "active" and "passive" movement. Boas stated:

> Active movement is consciously self-directed, while passivity allows movement to happen. Anyone who has experienced passive movement will know that there is a heightened consciousness of tensions, space relations, emotions, which is arrived at through a period of stillness. Passivity can lead to extreme activity, precisely because of this sensitivity to all stimuli both internal and external. (1971, pp. 22–23)

It is this "passive" approach which Boas was referring to in the eyes closed approach to improvisation. It is very similar to the approach used by Whitehouse and the Whitehousian distinction between the "I move" (active) and the "I am moved" (passive) experience. Both Whitehouse and Boas were deeply influenced by Wigman's ideas about improvisation. What differentiated Whitehouse's work, in part, was her reliance on Jungian analytic concepts to define what she observed in the movement process. This approach to improvisation or psychomotor free association used by both Boas and Whitehouse in their studio work, continues to be used today by many Whitehouse disciples and others who work primarily with the normal and neurotic adult population. Elements of this form of improvisation can also be seen in the work of Hawkins, Espenak, and Evan.

Summary

Boas pioneered in the integration of dance and movement into a psychotherapeutic modality in two settings. The first was as part of a research team which included the work of Lauretta Bender and Paul Schilder at Bellevue Hospital in New York. The second was within her own studio working with dancers. Boas integrated three major ideas prevalent at that time: 1) the building of body image through movement explorations; 2) the use of projective techniques in psychotherapy; and, 3) the use of free association.

Boas, influenced by the changing view of dance and psychology so prominent in the 1930's and 1940's, helped to usher in a new form of expressive and creative dance that integrated both the aims of the art of dance and the science of mental health.

Elizabeth Rosen

Elizabeth Rosen wrote the first book on dance therapy, *Dance in Psychotherapy*. Originally prepared as a dissertation for her Ed.D. at Columbia University Teachers College, her book was published in 1957 by the university's Bureau of Publications. This manuscript stands out as the first comprehensive study of dance therapy within the hospital milieu. Because Rosen stopped practicing soon after her study was completed, and because the book was taken out of print, her contribution has not always received the recognition it deserves. Much of the following discussion of Rosen's work is based on this pioneering publication.

Rosen directed the dance therapy programs at Hillside Hospital and Manhattan State Hospital, and taught a course in dance therapy at Brooklyn State Hospital in 1959. Her students included two of today's prominent dance therapists, Phillis Lipton and Claire Schmais. Rosen developed her own style of intervention through a process of trial and error. She drew a correlation between the patients' emotional needs and the roles they assume in a dance therapy group situation.

In her book, Rosen discussed five major aspects of dance therapy: 1) the broad objectives of dance therapy; 2) educational and creative styles of movement facilitation; 3) the therapist's role; 4) patient reactions to dance therapy; and 5) dance therapy in a hospital setting.

Rosen outlined three broad objectives of dance therapy: physical, social, and psychological, with specific aims depending on the individual needs of the patients. For example, the physical objective for lethargic patients was to condition their bodies through simple techniques such as bending and stretching as a way to get them accustomed to physical activity. For manic patients who needed to avoid stimulating activity, the stress was on structured techniques which demanded disciplined body control along with relaxation techniques.

The social objectives varied, depending on the patients' capacities for social interaction. The objective for the severely withdrawn was to arouse some responsiveness through kinesthetic reaction to rhythm and movement. For patients who had problems with aggression, the objective was to teach social control by rechanneling their aggression into dance movement

Franziska Boas, Victoria, 1986. (Photo courtesy Baos and D'ter.)

responses. In the case of the more socially mature patients, cooperative group activities and group improvisations were emphasized.

The overall psychological objective was to help the patients use dance to express and satisfy individual needs. The withdrawn and more timid patients were given continuous support and reassurance. Feelings of unity with and acceptance by the group were fostered by the use of simple, rhythmic group movements performed in circle formation with the patients holding hands. Folk dances and ballroom dancing provided a satisfying social experience for self-conscious patients who would feel threatened by more unconventional forms of dance, while the dramatic dance offered a socially acceptable way for the more aggressive patients to express hostility. Patients with exhibitionist tendencies were given opportunities to lead the group, and improvisations and pantomines were stressed.

Rosen viewed the therapist's major role as twofold: first, to provide individual support; and second, as a group catalyst. Because of this dual role, she brought in an assistant leader to co-lead the groups.

In her discussion of the hospital atmosphere, Rosen covered a broad spectrum of concerns which pertain specifically to dance therapy in the hospital setting. In particular, she noted three problems which she faced in regard to the hospital milieu and to the formation of a group. First, the physical environment was very distracting, with a constant stream of people walking in and out. Also, there was no confidentiality because the patients could be seen by the doctors and nurses. Second, the broad age range within the group created special problems in that the older patients had different physical needs and abilities from the younger ones. Finally, there was a constant shift in patient load, with discharges, new admittances and transfers. Also, shock therapy and psychotherapy were often scheduled at times that overlapped with the dance sessions. These factors, she believed, reduced the effectiveness of the group as a cohesive, integrating force.

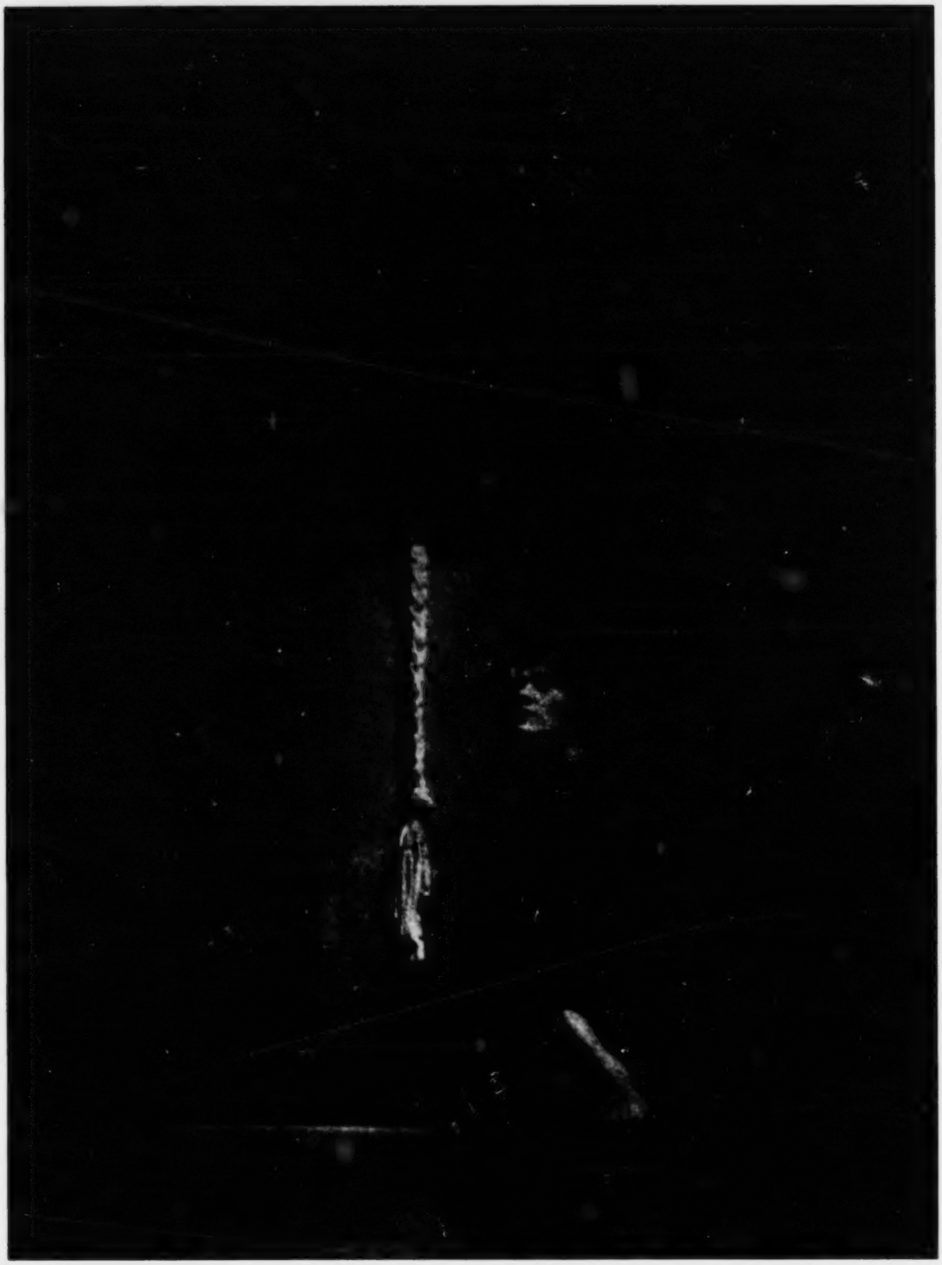
Hillside Hospital: The Open Ward

Rosens social objective of creating a sense of belonging to a group was realized most fully on the open ward. The dance sessions were elective for the open ward group and each came with a desire to dance. These patients required much less support from the leaders and were able to use a variety of group structures without loss of group identification. In addition to the circle formation, patients were able to work in small groups, in lines, or scattered throughout the room. The clique of "regulars" that came to the dance sessions became a tight-knit group, very close to each other and deeply committed to the dance therapy sessions.

Many of Rosen's patients were motivated to join the group by a desire to learn how to use their bodies effectively. They wanted to acquire better body control and coordination and to expand their range of movement. Here, they were expressing solid ego-oriented needs for control, mastery, effectiveness, and so on. They recognized that learning the basic skills of dance would help them reach these goals.

Accordingly, at least one third of each sessions was devoted to technical exercises. The patients were trained in all the fundamentals of body technique and rhythm, which were presented in a highly structured form moving from the simple to the more complex. With frequent repetition of these basic tools, the patients gradually developed a repertoire of movement techniques and simple folk dances which provided them with a feeling of accomplishment.

The most challenging approach for these patients was the use of dramatic ideas and themes. Concepts that were not too threatening or personal, such as "storm," "searching," or "sorrow," were used to stimulate creative expression in movement. Rosen noted that certain words and ideas are deeply rooted in cultural traditions and evoke stereotyped reactions that tend to cover up real emotional responses. Like Boas and Evan, Rosen believed that by applying the



Franziska Boas and Claude Marchant in performance. (Photo courtesy Gertrude Michelson and Franziska Boas.)

"free association technique" to movement, the motor responses to certain words and ideas could be used as a projective method. For Rosen's patients, learning how to project the feeling and quality of certain concepts opened up new avenues of communication through movement. It also helped them to appreciate dance as an art form rather than merely as the perfection of technique and body control, which, as mentioned earlier, was the initial motivation that prompted most of them to join the dance sessions.

In regard to the overall results of the improvisational work of the open ward group, Rosen stated:

> While the majority of patients did develop a sense of ease and confidence in movement which enabled them to participate freely in the creative work of the group, individually they exhibited frustration and conflict about doing anything alone. Improvisations were willingly attempted when everyone "did them together" and when no special point was made about "showing it" to the others. (p. 122)

Nevertheless, once the group had established cohesion, the creative movement experience became more personally meaningful to the patients and they began to recognize that these activities were therapeutic. Some found their identity through dance. For example, one patient, who was diagnosed as catatonic schizophrenic with initially a poor prognosis, began to realize her potential as a dancer through this program. On discharge from the hospital, she aggressively pursued a successful career as a dancer. Another patient became attached to the dance therapy process, feeling he was getting more from it than from his psychotherapy. He said:

> From the beginning I felt (or hoped) that this dance form had potential importance for me. Something made me seem to yearn for this type of expression. Buried feelings pushed for the opportunity to be freed; or perhaps more accurately, I pushed the feelings, trying to find some way of expressing them through the use of my body.
>
> Modern Dance helps me experience feelings which I have seldom been able to express or release. For example, when you make a conscious effort to express joy through movement, this feeling is released to some extent and you learn what it feels like. And familiarity with a feeling will probably decrease resistance to expressing this feeling in other situations. Anxiety about expressing feeling is reduced. (p. 129)

Manhattan State Hospital

As was the case at Hillside Hospital, the purpose of the dance therapy program at Manhattan State Hospital was research and observation. The project was directed by Rosen with the cooperation of hospital staff members.

The dance sessions were held twice weekly for 15 weeks, with each session lasting approximately one hour. The group originally consisted of 12 female patients between the ages of 20 and 40 who were selected on psychiatric referral. Of these, two dropped out and the study covers the remaining ten. All of these patients were diagnosed as psychotic-catatonic or paranoid. All were considered chronic and had undergone either electric shock or insulin therapy during the previous two years. Their general characteristics were physical deterioration, slovenliness, sluggishness, docility, and acquiescence.

The dance sessions took place in the recreation hall, a large open room, and the patients were brought in by an attendant. In the initial session, the patients entering the hall showed no response to the lively music that was being played or to the leaders who were moving about freely, nor did they react to the physical spaciousness of the large room after being confined in the narrow halls of the wards. Rather, they passively followed the attendant to one part of the hall where they sat down and waited quietly until the session formally began. Only then did they come out on the floor to dance. They followed this same routine in all the subsequent sessions.

During the first few sessions, the patients were introduced to very basic types of movements, including running, skipping, and waltzing with rhythmic accompaniment and relaxing and stretching techniques. All of these exercises were very simple, presented in highly structured and repetitive form. The goal of the leaders during this introductory period was to assess the abilities of the patients, to offer them support and reassurance, and to help them get used to the medium of movement. Throughout this time, the patients responded automatically, without interest or personal involvement. The activity seemed to have no meaning for them and they performed without conscious awareness.

Rosen, suspecting that the techniques being used were too structured and simple, decided to adopt a new approach that might challenge the patients to express their feelings in words and movement. She introduced two methods. The first was a direct question technique presenting an idea or theme. Questions such as "How does one show anger?" were asked to stimulate the patients to express themselves verbally and in movement. This method was successful in arousing some individual responsiveness.

The second method, the interpretation of music, evoked a much less intellectualized kind of movement and feeling than the direct question method. The patients responded best to familiar music, such as lullabies, military songs, hymns, folk songs, and jazz recordings. The rhythm and quality of the music and its cultural and personal associations seemed to arouse and awaken the patients "flashes of recognition, penetrating deeply into long-forgotten memories. . . . Patients who had previously appeared totally out of contact could thus be drawn into a reality response" (p. 161).

Musical selections from other cultures were also used. The patients did not respond well to the strange rhythms of Far Eastern music, but African tribal music and the drum rhythms of Haiti were extremely successful. It was discovered that movement responses were generally freer and less stereotyped when the music was more primitive, as was the case with the African and Haitian music. The patients abandoned themselves to the power of the rhythm and their movement interpretations were uninhibited, almost instinctive. Sometimes, the patients responded as a group, spontaneously creating a dance with unity; other times they responded individually.

The change in approach from simple movement techniques to creative expression through the interpretation of music and the dramatization of ideas aroused responsiveness from the patients. While the response during the early sessions was detached and mechanical, the dance took on extra meaning when the patients were encouraged to "do it their own way." Verbalizations increased noticeably and the patients began to react with greater awareness to the leaders, establishing various kinds of relationships with them. Rosen does not describe exactly how this came about, that is, whether she moved with the patients, directed them, or just put on music and waited.

This greater responsiveness to the encouragement of creative expression versus the use of simple movement techniques is very interesting in light of the common assumption that the more disturbed the population the greater the need for structure. This assumption had been supported at Hillside Hospital where the less disturbed open ward patients responded well to improvisational work while the more disturbed patients needed structure. Yet, at Manhattan State, where the patients were severely disturbed, the opposite was true.

The patients at Manhattan State Hospital were able to achieve *some* degree of group participation through the physical act of dancing together, and there were occasional moments of group unity. While major interactional changes did not occur, the patients' "... kinesthetic response to movement and rhythm ... proved to be the most effective means of initiating social participation. ..." (p. 181). In addition, on the individual psychological level,

> ... the dance did offer certain patients a usable medium for self-expression and a means of releasing ideas and feelings previously unexpressed. It provided a whole new area for acting out conflict and fantasy. (Rosen, 1956, pp. 182–183)

Summary

Rosen categorized her findings regarding patient reactions to dance therapy into the following patterns.

1. Withdrawn. The patients who reacted according to this pattern were generally submissive, obedient, and detached. Their responsiveness to movement was basically an empathic one, and they were highly dependent on the support of the leader. They responded best to techniques involving simple and natural movements of the body performed in a circle formation with a strong rhythmic accompaniment.

2. Self-conscious. These patients were generally apathetic, keeping careful control over their emotions, and were extremely conscious of being watched or observed. They participated in exercise techniques and in social dancing but were embarrassed by more creative or primitive movements and avoided all free, expressive improvisations.

3. Aggressive. These patients were hostile, suspicious, and very defensive. They used dance to express their aggressive feelings, often manifested in strong, thrusting movements, and frequently argued with the leader and criticized the other participants. Finding the structure of the circle or group dance too restrictive, they responded best when performing dramatic improvisations or pantomine.

4. Exhibitionist. These patients used the dance to satisfy their need for approval and recognition. When they were being watched and admired by others they participated with great enthusiasm. Otherwise, they either quickly lost interest or became disruptive.

5. Intellectual. These patients were generally intelligent but unable to express real feelings. They were attracted to dance as a means of releasing emotion and participated enthusiastically in dramatic improvisations, verbalizations about the dance, and interpretations of music.

6. Voyeuristic. These patients did not participate in the dance but were very involved as spectators and felt a strong identification with the group. They often responded with small body movements or rhythmic swaying.

Rosen's *Dance As Psychotherapy* was an important contribution to the discipline of dance therapy. It provides an in-depth, detailed, and systematic discussion of the initiation and development of two early dance therapy programs. Although not published until 1957, Rosen's study began in 1952, long before dance therapy was a recognized profession. Rosen's scholarly approach elicited support from both the psychiatric and psychological professions. This enabled her to work closely with other hospital staff, and as a result her study became a collaborative effort in which each contributor benefited them the expertise of the others.

Central to Rosen's work as a dance therapist was her willingness to experiment. When she found, for example, that patients were not responding to simple prescribed movements, she abandoned her initial concept of teaching movement and moved to improvisation. Rosen actively pursued a trial and error process of treatment, with few—if any—preconceived ideas about how things "should" evolve. This flexibility was the cornerstone of her success with the most regressed patient groups.

Dance Therapy Study

In 1956, a study was conducted by the Dance Therapy Study Committee of the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD), National Section on Dance. Its purpose was to assess the state of the art and practice of dance therapy and to explore the future of the field. This study was done in two parts, one in the United States and one in England.

For the study conducted in the United States, 56 questionnaires were sent to people in the dance and recreational fields. Additional questionnaires were enclosed to be sent to interested psychiatrists or administrators. The questionnaire inquired about their backgrounds, their definition of dance therapy, their methods, and their views on opportunities within the field.

Twenty-five dance therapists and eight administrators (including four psychiatrists in administrative positions) responded. Twenty of the dance therapists who responded worked in mental hospitals, clinics or agencies. Five of them worked with the blind, deaf, orthopedically or neurologically handicapped, or mentally retarded. From their responses a workable definition of dance therapy was reached:

> *Dance therapy is the use of dance as a carefully guided tool to produce desirable physiological, emotional and/or behavioral changes in emotionally or physically handicapped persons* (Hood, 1959, p. 18).

These changes were found to be in the areas of "alleviation or correction of physical difficulties, release of tension, development of awareness, acceptance of self and others, effective social interaction" (Hood, 1959, p. 18).

In regard to the training of these early leaders, the questionnaires revealed that most had degrees in physical education, recreation, or music therapy. Concerning dance training, some had very little and others had extensive dance backgrounds; only one had no dance training at all. Seventeen had studied modern dance and one-third had experience in several dance forms including modern, tap, ballet, jazz, folk, square and ballroom. Nineteen studied psychology and about two-thirds had on the job training. Eight studied with Marian Chace directly and three with Rudolf Laban.

Dance therapy was found to be one of the newer and less known treatment modalities. It was considered "experimental, improvisational, [and] uncharted . . ." (Hood, 1959, p. 18). However, responses from the questionnaires revealed that the use of dance as therapy was received enthusiastically in the setting where it had been tried. Dance as therapy was reported as being used for: 1) the experience of feelings (e.g., sexuality, hostility, depression); 2) physical benefits; 3) interaction; and, 4) as a bridge to verbal interaction with others, hence, as preparation for psychotherapy.

The committee that conducted the study suggested that dance educators should become familiar with dance therapy techniques and research. They stated: "Dance therapy has grown out of the educational approach to dance; in turn, research in dance therapy may contribute to dance education" (Hood, 1959, p. 72).

The companion study conducted in England revealed that the use of movement as therapy was more firmly established and was recognized by more psychiatrists in England than in the United States during the mid-1950's (Wooten, 1959). While American dance therapists at that time came from a wide variety of backgrounds and experimented with various techniques, the vast majority of English dance therapists (including all of those who responded to the questionnaire) based their work on Laban's *Art of Movement* (Wooten, 1959).

Five dance therapists, one psychotherapist, one psychiatrist and one lay analyst responded to the questionnaires sent out in England. Of the five dance therapists, one worked very closely with a psychiatrist, three worked independently of psychiatrists, but all had some patients who were also under psychiatric care. Many psychiatrists in England at this time viewed dance therapy as an alternative to psychoanalysis and sometimes referred patients to a dance therapist. However, most of the people who came to dance therapists did so because they were under stress but did not want to consult a psychiatrist.

All the dance therapists who responded to the questionnaire used movement as the only therapy for some patients. Five uses of movement therapy were identified:

1. Movement as communication, that is, as a means for making initial contact and establishing rapport with the patient.
2. Group movement for social adjustment.
3. Movement as creative expression for the individual, that is, as a means of bringing the unconscious to consciousness and thereby helping the individual get in touch with his/her inner state.
4. Movement as expressive of the individual, that is, the dance therapist could learn about the individual's personality and capabilities by notating and analyzing his motion rhythms using Laban's framework.
5. Movement as an impressive agent, that is, movement has specific meanings in terms of the individual's personality. Wooten explains:

> The impression made on the individual by his use of effort and space is specific and predictable, each aspect of his personality being linked with a definite apsect of movement. For example, man's sensory self is linked with his use of weight, his intuitive self with time, his thinking mind is linked with his use of space, his feeling or emotional self with flow. (Wooten, 1959, p. 76)

As is clear from numbers 4 and 5 above, English dance therapists in the mid-1950's were greatly influenced by Laban's teachings. However, this "new development" was not, at that time, "widely recognized or understood," but showed "great promise" as "a valuable means for reintegrating the disturbed personality" (Wooten, 1959, p. 76). In the United States, it was not until the mid-1960's that Laban Movement Analysis became important to the work of dance therapists.

The Dance Therapy Study, conducted in 1956 by AAHPERD's National Section on Dance, was an important benchmark in the history of dance therapy. Done in two parts, one in the U.S. and one in England, its purpose was to assess the state of dance therapy practice, and to explore the future of the field. The results reflected some important trends and helped to define the profession in terms of its roots in dance psychotherapy, its goals, its acceptance as a discipline, the therapists who were practicing and the clients they served.

Discussion

Dance Therapy Outline—1960

The following outline depicts the state of the practice of dance therapy in the early 1960's. The outline was derived from an analysis of the clinical contributions of the major pioneers discussed in Chapters 1–8. The items designated by Roman numerals represent overall categories of intervention. Listed beneath these major headings is a breakdown of the various methods used alternately by the pioneers. Interestingly, the outline indicates that by the early 1960's, dance therapy had already achieved a very broad and complete base of practice. What the following decades would bring to the art of dance therapy was not so much new techniques, but a more in-depth, well-defined understanding of why the practice of dance therapy works, that is, theorectical foundations. While dance therapy techniques today are being refined and expanded and new patient-client groups are being reached, it is clear that the practical foundations were well developed and extremely diversified quite early in the history of the discipline.

DANCE THERAPY OUTLINE

DEPICTING THE STATE OF THE ART BY THE EARLY 1960'S

I. Warm-up and Body Awareness Techniques Included:

A. articulation of body parts (e.g. rotations and swings);
B. rhythmic movements, explorations and games;
C. repetitive movements;
D. education in the rudiments of movement;
E. introduction to basic dance steps (e.g. folk, social, etc.).

F. use of props (hoops, scarves, percussion instruments, etc.);

G. relaxation and breathing techniques;

H. exploring tension fluctuation and extremes;

I. exploring contrasting movement themes (extremes and gradations) (See III K);

J. body awareness techniques;

K. postural explorations;

L. projective techniques;

M. the use of music as a facilitator of movement and as a background support.

II. Expressive Dance/Movement Activities Included:

A. psychomotor free-association through:
   1. improvisation,
   2. active imagination,
   3. dream interpretation,
   4. fantasy explorations,
   5. reenactments of childhood memories,
   6. projective techniques,
   7. spontaneous dance/movement interpretation of music; and

B. the exploration of ambivalence and emotional conflict through:
   1. role-playing,
   2. the exploration of contrasting movement themes—spontaneous and choreographed, and
   3. choreographed explorations of emotions (see Schoop-planned movement).

III. Dance Forms Used By The Pioneers At Various Times Included:

A. rhythmic action and repetition;

B. exaggeration of expression;

C. improvisation;

D. choreographed or planned (rehearsed) movement;

E. dramatization;

F. folk;

G. modern and creative;

H. ballet;

I. social;

J. ethnic; and

K. the exploration of movement dynamics—variations in space, weight and time (e.g. sustained movements vs. fragmented movements, direct movements vs. indirect movements, light movements vs. heavy movements).

IV. The Therapeutic Interaction with the Dance Therapist Included the Therapist:

A. mirroring and reflecting patients' feelings back to them through a dance/movement interchange (see Chace & Schoop);

B. reacting and responding through movement to patients' needs and nonverbal communications (see Chace & Schoop);

C. engaging in playful movement dialogues as in the creation of games, fantasies and dramatic movement interactions;

D. verbally narrating and reflecting the conscious and unconscious thoughts and feelings of patients during the dance/movement process;

E. empathizing, observing and listening (see Evan & Whitehouse);

F. teaching body movement; and

G. guiding the patient through the personal unconscious to the collective unconscious (see Whitehouse).

V. The Early Dance Therapists used verbalization For The:

A. elicitation of thoughts and feelings;

B. facilitation of insight;

C. exclamation of thoughts and feelings while moving;

D. reflection and narration of the psychomotor process;

E. identification of the body in stillness and in action—naming body parts and what they are doing (e.g. raising arms, stamping feet, etc.);

F. facilitation of movement; and

G. interpretation and integration.

VI. Group Dance Therapy Techniques Included:

A. shifting of leadership roles within the group;

B. changing group constellations:
   1. dyads and triads,
   2. small clusters,
   3. large group,

    4. individual action within the group,
    5. circle—clasped and unclasped hands, and
    6. various line formations;

C. promoting the rhythmic group relationship (see Chace);

D. promoting supportive empathic group interaction (verbally and nonverbally);

E. supporting the satisfaction of various role needs through controlled acting-out (see Rosen); and

F. role-playing.

VII. Music and Rhythm Were Designed To:

A. help organize patients' thoughts and feelings into expressive action;

B. support and encourage self-expression;

C. facilitate improvisation;

D. reflect patients' moods and needs;

E. facilitate rhythmical action and expression;

F. motivate and activate; and

G. create emotional responses.

UNIT II

Subsequent Development of Dance Therapy

The dance therapists discussed in Unit I made significant contributions to dance therapy in the 1940's and 1950's, at a time when it was not yet a recognized or organized profession. Their contributions paved the way for a period of rapid growth which began in the late 1960's and was inspired, to a large degree, by the development of the American Dance Therapy Association in 1966. The association was organized to "establish standards of professional competence, to encourage training and education to fulfill these standards, and to effectively communicate to those in allied fields and to the general public the aims and achievements of dance therapy" (ADTA, 1966).

In the years that followed, with the ADTA's successful achievement of these goals, the profession made the transition from infancy to early adulthood. Many new and innovative leaders emerged in the late 1960's and during the 1970's who made unique contributions to the field through their positions in the ADTA as teachers and creators of educational programs and/or through publications. These leaders laid the professional foundation which enables today's dance therapists to practice privately and in recognized educational institutions as well as mental health, medical, and psychiatric facilities.

In addition to contributing to the professionalization and institutionalization of the field, leading dance therapists during this period also contributed to the expansion of dance therapy theory and practice. The evolution of the work of the major pioneers of the 1940's and 1950's is clearly reflected in the work of the succeeding generations of dance therapists, who were trained either directly by one or more of the pioneers or by their disciples, and who have expanded upon the approaches of their mentors in a variety of ways.

Some, for example, have carried on the work of the pioneers, broadening and clarifying specific theories and techniques, or adapting them for use with particular populations. Others have integrated into the approaches of their mentors ideas and methods from other related fields. Still others have developed approaches that incorporate aspects of the work of two or more pioneers, and in recent years there have been indications of a merging of east coast and west coast influences. These trends can be seen as an extension of the tradition set by the original pioneers themselves, many of whom developed their approaches through a merging of influences from, for example, their experiences as modern dancers and/or creative dance teachers, and from pre-existing theoretical frameworks (i.e., the work of Jung, Sullivan, Adler, etc.).

Because of the rapid growth of the field during this period and the proliferation of dance therapists who have made contributions, the focus of Unit II shifts away from individual dance therapists and revolves instead around key developments in dance therapy theory and practice. Section A examines the impact of Laban Movement Analysis, introduced in the United States by Irmgard Bartenieff. Section B focuses on other areas of theoretical and practical expansion, specifically, the integration of psychoanalytic thought by dance therapists on the east coast, the expansion of the Whitehousian approach by dance therapists on the west cost, and the incorporation of other action-oriented psychtherapies (i.e., Gestalt therapy and psychodrama). Section C reviews a compendium of dance therapy literature, written largely over the past two decades, emphasizing the contributions of dance therapists in organizing and synthesizing theories and techniques specified for particular patient/client populations.

SECTION A

Laban Movement Analysis And Dance Therapy in the United States

9

The Theoretical Contributions of Laban and Lamb

The theories of Rudolf Laban, originated in the early 1900's, became integrated into the therapeutic use of dance and movement among English dance therapists in the 1950's. Warren Lamb was a protege of Laban who expanded on Laban's original concepts. It was not until the mid-1960's, however, that the theories of Laban and Lamb became popular among dance therapists in the United States. At that time, when dance therapy was still a fledgling profession, Laban's teaching provided a method of movement analysis and a system of notation which placed dance therapists on their own professional ground, giving them a language for describing patients' movements, and eliminating the need to rely on less accurate jargon borrowed from other disciplines.

Various terms are commonly used in referring to Laban's work. The term "effort/shape" refers to Laban's effort system and to Lamb's shape system. Some dance therapistis, who do not use Lamb's shape system, simply use the term "effort," while those who use Laban's complete theoretical framework refer to "Laban Movement Analysis," "Labanalysis," or "LMA."

Laban viewed body movement in a complicated and multifaceted way. He saw its potential use as an expressive medium of both conscious and unconscious thoughts, feelings and conflicts, and also a vehicle through which societies pass on traditions, coping behaviors, and religious rituals.

> Man moves in order to satisfy needs. He aims by his movement at something of value to him. It is easy to perceive the aim of a person's movement if it is directed to some tangible object. Yet there also exist intangible values that inspire movement. (Laban, revised Ullman, 1971, p. 1)

Laban continually impressed on his readers the variety of ways in which we express ourselves and our particular styles of coping through what he terms our movement configurations. For example, some individuals meet a problem energetically with quick, direct actions, while others circle an issue in a sustained manner for several days before coming to a conclusion.

Laban also stressed the individual's capacity, as compared with that of animals, to change his/her style of communication and adaptation through both conscious and unconscious mechanisms. Comparing animal movements to human movements, and correlating his thoughts concerning the complexity of the human movement potential with one possible cause of human conflict, Laban said:

> It appears that the effort (exertion) characteristics of man are much more varied and variable than those of animals. One meets people with cat-like, ferret-like, horse-like movements, but one never sees a horse, a ferret, a cat exhibiting human-like movements. The animal world is rich in effort manifestations, but each animal genus is restricted to a relatively small range of typical qualities. Animals are perfect in the efficient use of the restricted effort habits they possess, man is less efficient in the use of the more numerous effort shadings potentially possible to him. It is not surprising that more numerous and vehement conflicts should arise in human beings possessing the capacity for such manifold and often contradictory combinations of effort qualities. (Laban, revised Ullman, 1971, p. 11)

Laban's keen observational skills and his attention to form and content grew out of his theater and performing background and his interest in architecture. His investigation of movement began in Central Europe where he experimented with three different forms of movement: traditional forms in fencing and ballet; modern forms, which led to the development of the early modern dance style of Central Europe; and, formalized work movements (Dell, 1970). Out of this experience Laban developed a system of movement description called Kinetography Laban or Labanotation, describing *what* body parts move, *when* and *where*.

Later, when Laban was asked to conduct efficiency studies for British industry during World War II, he investigated the qualitative aspects of movement, that is, *how* a person moves. This resulted in his development of a system of movement description which attempted to describe all the possible ways we move in terms of the concept of exertion (effort). Later, growing out of Laban's work, Lamb's (1965) concept of "shape" was introduced as a correlate of "effort" (Dell, 1970), resulting in "effort/shape."

Basically, effort/shape is "a method of describing changes in movement quality in terms of the kinds of exertions [effort] and the kinds of body adaptations in space [shape]" (Dell, 1970, p. 7). These two distinct though interconnected concepts are widely used by dance therapists today.

Effort

Effort describes movement dynamics in terms of four motion factors: space, weight, time, and flow. Each movement factor has two opposing possibilities called "elements": the individual's use of space can be either "direct" (the shortest distance between two points) or "indirect" (circuitous); the use of weight can be "strong" (using greater exertion) or "light" (using less exertion); the use of time can be "quick" (sudden) or "slow" (sustained); and finally, flow can be either "bound" or "free" (representing the ease or restraint of the movement).

It is impossible to isolate one movement factor or element. Each movement factor is dependent on certain other factors. What varies is the intensity and combination of movement elements which dominate at a given moment. Thus, in observing the movement of a patient, the therapist tries to discover which movement factors or elements are present as part of the larger movement configuration and context.

In using effort, movement characteristics are often discussed in relation to personality

Rudolf Laban's Movement Choir (early 1900's)—exploring large group movement. (Photo courtesy The Laban-Bartenieff Institute of Movement Studies, New York.)

attributes. The movements seem to come alive and have more meaning when discussed in this way. However, this can be misleading and convey emotional overtones not actually inherent in the individual's movement behavior. Also, one must be cautioned against possible judgmental aspects of the effort terminology when used in this way. For example, an indirect use of space does not necessarily mean an inability to cope with space or life directly, but rather a preference for a certain style of coping. Similarly, concerning the strong versus light use of weight, an individual who uses mostly movements of "strength" does not necessarily have a stronger or more assertive personality than an individual who uses "lightness."

To guard against making simplistic interpretations of personality structure, therapists need an understanding of movement from a psychological, anthropological, and sociological perspective. Moreover, the therapist must not lose sight of the whole movement process and get lost in the parts.

Shape

The concept of shaping was introduced by Warren Lamb (1965). Whenever an individual makes a change in his/her use of effort elements, a corresponding shape change occurs. Shape describes the "where" of movement, that is, where the body forms itself in space. There are three kinds of shape changes that are observed in Laban Movement Analysis: 1) shape flow; 2) directional movement;[1] and 3) shaping movement.

For shape flow, the observer looks at changes between body parts moving towards or away from each other. For directional movement, the observer looks at the paths of movement in space which are either arc like or spoke like. These one or two dimensional movements tend to be characteristic of functional activity. For shaping, the observer looks for adapting or molding movements such as holding an infant. These are usually two or three dimensional movements.

The primary leader responsible for the timely introduction of Laban and Lamb's concepts in the United States was Irmgard Bartenieff. Bartenieff was a pioneering leader in dance therapy and a protege of Laban. In Chapter 10, the relevance of LMA and effort/shape will be explored through a discussion of Bartenieff's contribution.

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[1] The concept of shape flow was derived from the work Forrestine Paulay was doing with Judith Kestenberg. The concept of directional movement was developed from the work that Paulay and Bartenieff were doing in the choreometrics project—a cross cultural study of movement style, with Alan Lomax at Columbia University.

10

Irmgard Bartenieff

Irmgard Bartenieff played an important role in the history and development of LMA and its application to dance therapy and physical therapy. She pioneered the integration of Laban Movement Analysis with her career as a physical therapist. Out of these two diciplines, Bartenieff created her own approach to body movement education which is known today as the Bartenieff Fundamentals (1980). This approach to body movement is re-educational in that it develops movement efficiency and expressiveness by emphasizing the spatial aspects of movement and incorporating them into efficient motor organization.

Born in 1900 and raised in Germany, Bartenieff was part of the early European modern dance movement of the 1920's. In 1925, she began her studies of Rudolf Laban's work in movement analysis. In the 1930's, Bartenieff had her own dance company, which toured Germany. She was impressed with Mary Wigman's work, but did not want to be influenced solely by Wigman's technique (Bartenieff, 1980, p.c.). Due to the political situation in Germany, Bartenieff, like Espenak and Polk, fled to the United States, bringing along her knowledge of LMA. She began teaching at several key places, including Bennington College, Columbia Teachers College, the Brooklyn Museum, the New School for Social Research, and the Hanya Holm Dance Studio in New York (Bartenieff, 1980, p.c.).

Bartenieff received her degree in physical therapy from New York University in 1943, and later worked with polio victims at the Willard Parker Hospital in New York. It was there that she began experiementing with movement techniques, an experience which later contributed to her development of the Bartenieff Fundamentals and of a philosophy based on the use of movement to promote mental health. In the 1950's, she continued to work with handicapped children at Blythedale Hospital in Valhalla, New York, and resumed her studies with Laban in England during the summers.

In her physical therapy work at Willard Parker and Blythedale Hospitals in New York, Bartenieff was particularly respected for her ingenuity in reaching children depressed by severe physical limitations, devising special games adapted to their needs and abilities. She emphasized the mobilization of movement forms which integrated emotional and motivational needs with physical needs (Bartenieff and Lewis, 1980). She was greatly influenced by her teacher, George Deaver, whose motto was: "activate and motivate" the patient (Bartenieff and Lewis, 1980, p. 1). Having personally experienced the hardships of escaping from Germany and supporting her family in the United States, she was well aware of the role of motivation in personal growth and in the ability to change and adapt. This concentration on activation and motivation later became her most natural means of working with both patients and students.

In the early 1960's, Bartenieff became associated with Dr. Israel Zwerling, Professor of Social Psychiatry at Albert Einstein Medical College Hospital and director of the Day Hospital at Jacobi in the Bronx, New York.[1] At the Day Hospital, Bartenieff was involved primarily in research projects, observing and notating nonverbal communication and interaction in family and group therapy sessions. She also began to explore the use of movement as an expressive medium for psychiatric patients. On one occasion, Zwerling happened to observe her intervention with one severely disturbed catatonic patient and was deeply moved by her ability to draw this, and other, individuals out through movement (Davis, 1980, p.c.).[2]

In the mid-1960's, Bartenieff went with Zwerling to Bronx State Hospital and continued her work in dance therapy and movement research. Whereas at the Day Hospital she worked with outpatients, at Bronx State she began to adapt LMA to therapy with the severly retarded inpatients.

It was at Bronx State Hospital that Bartenieff's work became formally integrated with the discipline of dance therapy.[3] Her contributions to the field were timely and crucial. She offered a system of movement obervation, analysis, and notation that could be used to guide, direct and describe dance therapy sessions. This was at a time when dance therapists were in need of a language that could communicate their clinical experience. Laban's and Lamb's contributions, applied practically and expanded by Bartenieff, represented a partial solution to this problem.

Bartenieff maintained an active interest in movement research throughout her career. From the 1940's through the mid-1970's, she was a prominent faculty member at the Dance Notation Bureau (DNB) in New York City. During this period, she presented Laban's concepts at the DNB and applied them in her physical therapy work and in the choreometrics project. Together with Davis and Paulay, she pioneered a training program at the DNB. It was there that many dance therapists were first introduced to Laban's work. In the late 1970s, Bartenieff and several colleagues left the Dance Notation Bureau to open their own training institute designed to specialize in LMA education. Bartenieff was a founding member and the first president of this new institute, the Laban Institute of Movement Studies in New York City.[4]

At the age of 80, Irmgard Bartenieff made her final contribution to the field of human body movement: her book entitled *Body Movement: Coping with the Environment*, co-authored with Dori Lewis and published in 1980.

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[1] Noted movement researcher Martha Davis (Bartenieff & Davis, 1965) was first introduced to Bartenieff and LMA at the Day Hospital. Davis assisted Bartenieff in her work and later at Bronx State Hospital, and has become a leading proponent of this form of movement analysis.

[2] Zwerling was extremely supportive of Bartenieff's work, respecting her both for her interaction skills with patients and for her talents in movement analysis and research. To this day, he has been a major proponent of the creative arts therapies, emphasizing body movement for research purposes, for diagnosis of family interactions, and most importantly as a form of primary therapy (Zwerling, 1979).

[3] Bartenieff and her assistant, Martha Davis, were soon joined by Elissa White and Claire Schmais. Their collaboration led to the development of the Dance Therapy/LMA program at Bronx State Hospital, which has become a major training ground for dance therapists. (See next chapter)

[4] After her death in 1981, the Institute's name was changed to the Laban/Bartenieff Institute of Movement Studies.

Bartenieff's emphasis on the perception of body movement as a complex, integrated whole permeated every aspect of her teaching. (Photo courtesy The Laban-Bartenieff Institute of Movement Studies, New York.)

Theory and Practice

Bartenieff's work stressed perceiving movement as a complex interrelated whole.

> What is critical to the comprehension of these perceptions is that they be understood as a whole—without fragmentation. Change in any aspect [of movement] changes the whole configuration. (Bartenieff & Lewis, 1980, p.x)

This perspective of body movement as a continually fluctuating process influenced Bartenieff's thinking in every area of movement analysis and intervention. Her conviction was that:

> behavior must be understood in relation to neurophysiology and total organic functioning. The effort-shape theory of movement is based on an organic model of behavior. The major hypothesis [is] . . . that neural processes, adaptation and expression are integrated in movement. Every movement in any part of the body is at once adaptive and expressive; it functions as a coping mechanism while at the same time it reflects something about the individual. (Bartenieff & Davis, 1965, p. 51)

Bartenieff believed that each individual's movement style was an amalgam of his/her congenital activity type, psychological influences, and the cultural milieu (Bartenieff & Lewis, 1980). Respecting one individual's unique physical expression of these influences, she worked creatively to help her patients make better use of what was already present in their movement repertoires.

Focus on potential movement expression

In clinical work with patients Bartenieff always looked at the total movement configuration with a major focus on the *potential* movement expression. The idea that potential movement was inherent in one's physical actions and movement preferences was derived from Laban's concept of "a diminished effort." If an effort was diminished, it remained present, but in small quantity. Hence, there would exist the beginning or partial utilization of certain effort and shape factors, which for one reason or another were only partially activated. Bartenieff did not attempt to explain, in formal psychological terms, why a specific movement factor might appear only in its diminished state, or why a certain quality of movement would not actually fully materialize. Instead, this was simply accepted and incorporated it into the total configuration.

Bartenieff cautioned the therapist against pointing out to a patient what movements they were lacking or requesting that the patient consciously work at producing a particular movement. Rather, she believed the therapist should study the total movement configuration available to the patient, and then non-verbally engage him/her in movement activities which, in accordance with the individual's specific movement preferences, would eventually draw out the diminished movement factor or element.

In following statement, Bartenieff described the circuitous process of reaching an individual who, for one reason or another, was not employing directness within his/her movement repertoire:

Bartenieff asserted that a successful dance therapist activates the patient's "independent *participation* in his own recovery." (Photo courtesy The Laban-Bartenieff Institute of Movement Studies, New York.)

> . . . the Directness deficiency . . . should be treated in the context of the patient's whole organization of Effort combinations and the accompanying spatial shape actions. The therapist may first start to explore all combinations of the patients's repertoire, such as Flow with Weight (Strength or Lightness), Flow with Time (Sudden or Sustained) and soon, from there, the therapist may gain access to the use of Directness in combination [with other movement factors]. (Bartenieff & Lewis, 1980, p. 148)

This was perhaps the essence of the Bartenieff philosophy and the resulting methodology, that is, finding the correct activities that would support the development of specific muscle systems, which, in turn, would effect certain emotional attitudes.

Another approach Bartenieff used, mostly with retarded patients, to help an individual develop a specific effort element—in this case "directness" (a space factor)—was playing physically active games. Since active games often require clear spatial intent on the part of the players, such activity would support the expression of this effort factor in a nonthreatening and often pleasurable way.

Bartenieff views dance therapy within a humanistic framework. Instead of focusing on the limitations or pathology of the personality as viewed through the body structure and movement behavior, Bartenieff looked at the total movement profile, with a major focus on the potential movement expression.

Motivation and the Use of Space

In helping hospitalized individuals to explore their movement potential, Bartenieff stressed the need to activate and mobilize the "movement impulse" (the motivational factor behind movement).

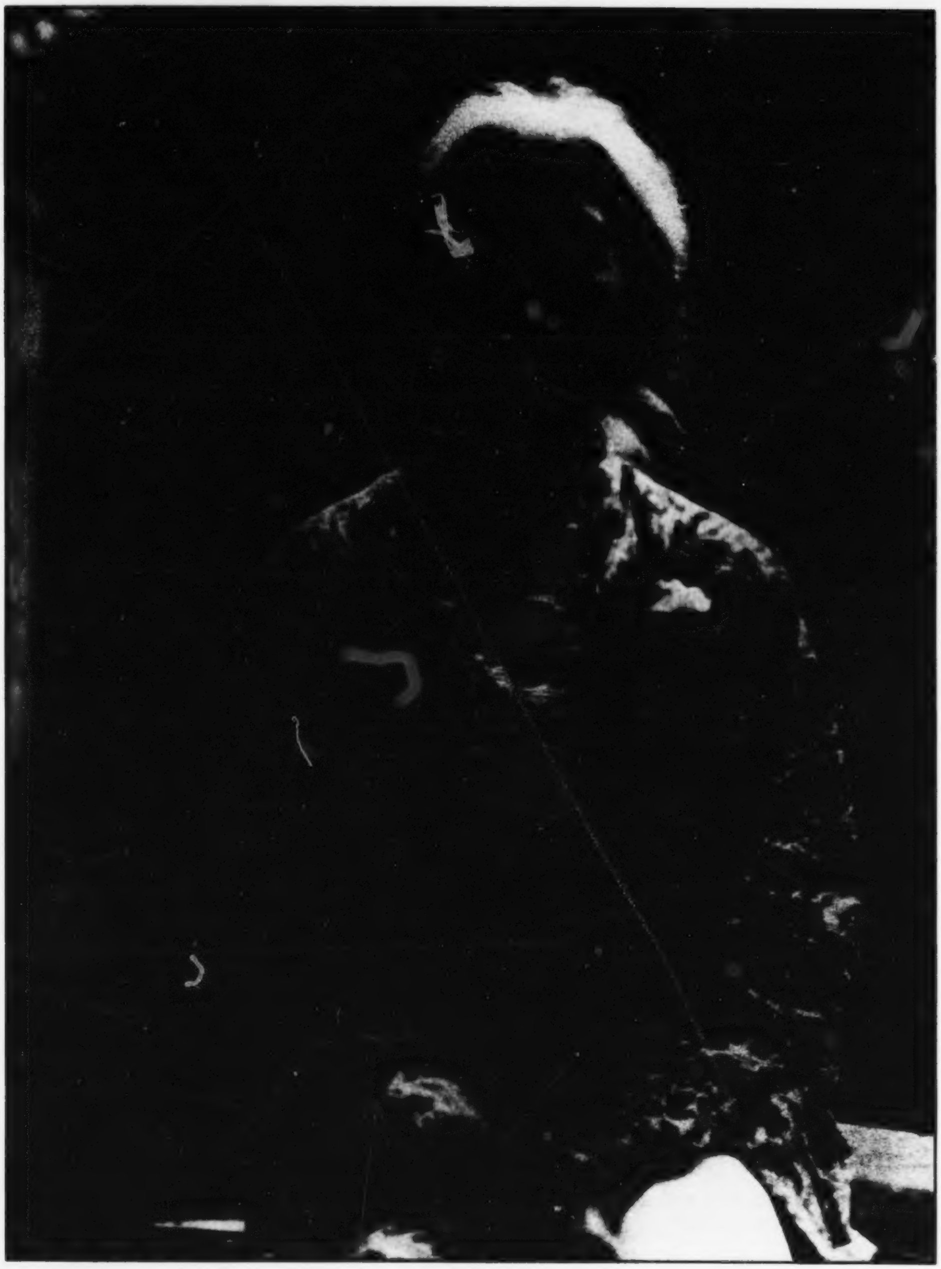
> My task, defined for me by this climate of stasis and regression [i.e., the hospital milieu], was to find ways of keeping alive the movement impulse—the root of all development impulse—the root of all development of a thinking, feeling, acting human being. This problem has continued to remain central to all my work with the emotionally disturbed and dealing with it is the key to dance therapy. (Bartenieff & Lewis, 1980, p. 9)

She found that movements which emphasized the creation of spatial designs (i.e., circular, angular, spoke like, etc.) elicited important emotional responses and attitudes in patients. Particular spatial pathways activated during dance explorations inspired the somatic externalization of specific thoughts and feelings. Through the incorporation of spatial designs, Bartenieff could further develop the patient's expressive movement vocabulary. However, she stressed that in order to successfully introduce spatial concepts, the dance therapist must be comfortable with and aware of the patient's intentions. Only if the therapist is attuned to the patient can he/she facilitate the patient's psychophysical connection to space via dance. If the dance therapist is successful he/she can activate the patient's "independent *participation* in his own recovery" (Bartenieff & Lewis, 1980, p. 3).

The Bartenieff Fundamentals

Out of her early experience working with both physically handicapped and emotionally disturbed individuals, Bartenieff later developed six specific body movement exercises, which are described in her book *Body Movement: Coping With the Environment* (1980). These basic exercises, called the "Bartenieff Fundamentals," provided the individual with "a means of becoming aware of some primary experiences of the self and being led from that to a clearer feeling of oneself in relation to others" (Bartenieff & Lewis, 1980, p. 146). They were specifically designed to help the individual integrate body feeling with emotional feeling and expression. "The functional and expressive contents of movement are two sides of the same coin" (Bartenieff & Lewis, 1980, p. 145).

The Bartenieff Fundamentals were also designed to enable individuals to unify their perceptions of three simultaneous activities: breathing, muscular fluctuation, and feeling. She purposely limited her verbal instructions, omitting statements such as "This is how you breathe." Instead, she encouraged her patients to develop a personal sensitivity to their body processes by having them do movement sequences that organically supported and facilitated the integration of the physical and emotional experiences of the self. The Fundamentals attempted to replace intellectualized movement endeavors which Bartenieff felt would only further fragment the mind and body, a state often already overemphasized in the disturbed individual (Bartenieff & Lewis, 1980).



Irmgard Bartenieff. (Photo courtesy The Laban-Bartenieff Institute of Movement Studies, New York.)

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The Fundamentals grew out of Bartenieff's early-held belief that contacting the motivational aspect of the individual's movement is the key to integrating physical expression with emotional expression, that is, unifying body and mind. In emphasizing the strength, potential, and uniqueness within the personality, Bartenieff supported the individual's self-acceptance. This, in turn, encouraged a more total actualization of the individual's movement potential, along with a more flexible and complete expression of self.

Focus on community/society

While the motivational aspect of movement focused mainly on the individual's relationship to self, Bartenieff also emphasized the individual's relationship to others and to society. She recognized the need not only for the integration of mind and body but also for establishing a healthy balance between internal and external demands on the personality.

Because the reality of life is that we do not live in isolation, Bartenieff emphasized movement as a tool which could bridge the gap between internal and external needs and demands, thereby integrating the subjective and the objective aspects of the individual's life.

> By projecting feelings into space through the body, the movements themselves are immediately communicative . . . The experience of building one's own organic structures in space can subtly build confidence in one's self. To do this with others helps to develop a sense of supportiveness from the community and an ability to make adaptations for the interdependence of that support. (Bartenieff & Lewis, 1980, pp. 144–145)

Her stress on bringing the subjective out into communicable form, adapting and shaping it so that it could be relayed, demonstrated her belief in the importance of the community and communal aspects of dance.

According to Bartenieff, the therapist's role was one of helping patients to find a satisfying mode of behavior which would enable them to live peacefully with themselves and with society. Freudians would view this as developing ego controls. She stated:

> When the focus of the therapist is only on the subjective, isolated, body level without any relation to space or . . . structure . . ., there is a great danger of getting the patient stuck in single aspects of his/her problem and increasing the fragmentation of his/her movement activity. (Bartenieff & Lewis, 1980, p. 144)

> What is most important for patient and therapist is to keep both intellect and feeling accessible and functional without fragmentation. The dance therapy discipline should not be permitted to deteriorate into amorphously indulgent self-expressiveness. Nor should it become so structured by mechanical measurements that the parts become greater than the whole. (Bartenieff & Lewis, 1980, p. 151)

Summary

Bartenieff's emphasis on the perception of body movement as a complex, integrated whole permeated every aspect of her teaching and her work, and was one of her major contributions to dance therapy. Her greatest contribution, however, aside from bringing Laban's theories to the United States, was perhaps her ability to communicate to others her dynamic understanding of the structure and function of movement.

11

Zeitgeist at Bronx State Hospital

In the mid-1960s, around the time Bartenieff began working at Bronx State Hospital, she and her disciple Martha Davis wrote an article entitled "Effort/Shape Analysis of Movement; The Unity of Expression and Function?" (1965). This article presented the following three assumptions regarding the use of Laban Movement Analysis. LMA:

1) is a replicable technique for describing, measuring, and classifying human movement;
2) describes patterns of movement which are consistent for an individual and distinguish him from others;
3) delineates a behavioral dimension related to neurophysiological and psychological processes. (Costonis, 1978, p. 90)

In accordance with these beliefs, Bartenieff used LMA as an observational, diagnostic, and assessment tool in her dance therapy work at Bronx State Hospital. Her work became formally integrated into the discipline of dance therapy in the late 1960s when the dance therapy staff at Bronx State was expanded and training programs for dance therapists and other hospital staff were instituted. These developments were due largely to the pioneering efforts of Elissa Queyquep White and Claire Schmais, in collaboration with Bartenieff and Davis.

White, a certified movement analyst, began working part-time at Bronx State in 1967 as a family therapy research assistant to Israel Zwerling, the Director of the hospital. Zwerling's research did not involve LMA, but White, coincidentally, was simultaneously training in LMA with Bartenieff, using the family therapy session at Bronx State as the subject of study. Later that year, White was employed there working half-time in research and half-time in dance therapy. Soon afterward Claire Schmais, who was teaching part-time at Hunter College, also joined the staff.

Schmais and White had met each other in the mid-1960s at a meeting of dance therapists interested in forming an association, and had become "friends and comrades" while working together, along with others, to form the ADTA (White & Schmais, 1986, p.c.). Both Schmais and White had previously taken courses with Bartenieff at the Dance Notation Bureau in New York City. They also had both taken a well-known dance therapy course with Marian Chace at the Turtle Bay Music School, Schmais in 1961 and White in 1963. In addition, Schmais had interned with Chace at St. Elizabeth's Hospital in Washington, D.C. for one year. Their joining the staff at Bronx State resulted in a historical and timely coming together of two previously distinct movement disciplines: the Marian Chace technique of dance therapy carried on by Elissa White and Claire Schmais, and the contributions of Laban and Lamb carried on by Irmgard Bartenieff and Martha Davis.

Soon after arriving at Bronx State, Schmais and White discovered that the progressive and innovative atmosphere at the hospital presented opportunities for expanding the use of dance therapy there.

> Dr. Zwerling literally opened the locked doors at the hospital and created a climate that was receptive to new ways of working with patients. Because our primary interest was in dance therapy we became intrigued with the possibility of setting up a dance therapy program at Bronx State Hospital. (White & Schmais, 1986, p.c.)

After consulting with the nursing supervisors and with the chiefs of services, Schmais and White began giving dance therapy orientation sessions for nurses and their staffs. The purpose was to "help them understand the role of dance therapy in the overall treatment plans of their patients, how they might best participate when they joined in the sessions with us and how we could contribute to their understanding of movement behavior" (White & Schmais, 1986, p.c.). These orientation sessions eventually became a part of the regular training for new attendants and student nurses.

As the demand for dance therapy sessions increased, White and Schmais set up [illegible] six week therapy training program for mental health workers and other staff interested in using this modality. The program focused on elementary dance therapy techniques in an effort to increase the trainees awareness of their own movements and the movements of their patients in sessions and on the ward. After completing the training, most of the participants began conducting dance therapy sessions on their wards. Though all of them like to dance, none had the in-depth dance training and dance teaching experience on which to base their dance therapy training. Unfortunately, it was not possible at that time to provide the ongoing support, dance training, and supervision they needed.

> Though the outcome was disappointing, as it did not increase the use of dance therapy throughout the hospital, these trainees were always tremendously helpful as assistants in sessions. Their training in observation helped them talk about their perceptions of the patients' movement behavior, be it in a dance therapy session or on the ward. (White & Schmais, 1986, p.c.)

In the meantime, the dance therapy staff at Bronx State was increasing. White became the director of the first dance therapy unit at the hospital, and by the late 1960's had facilitated the hiring of three full-time and five part-time dance therapists. This was a major triumph in that dance therapy was, and at times still is, fighting for professional recognition. As the dance therapy staff increased, and because Zwerling's philosophy was that all staff should have continuous education, White began conducting short-term workshops for recreation therapists to sharpen their observation skills. She also began classes with first-year psychiatric residents, introducing them to dance therapy and movement observation. These classes evolved into ongoing sessions with the residents at the hospital and became an integral part of their psychiatric training.

In 1969, in response to continued requests for dance therapy training, White and Schmais began giving one-week, intensive introductory dance therapy workshops. Because of the burgeoning interest in dance therapy, people came from all over the country to attend these workshops. Those who desired further training were able to volunteer at the hospital from three to five times a week for periods ranging from six months to a year. As a result of their experiences conducting these workshops, Schmais and White began to "formulate a philosophy of dance therapy training which involves the importance of understanding and knowing individual style, developing movement observation skills and knowledge of how movement interaction affects the group in dance therapy" (White & Schmais, 1986, p.c.).

They felt that given this philosophy and the enthusiastic response to training, Schmais (at Hunter College) should apply to the National Institutes of Mental Health for a curriculum development grant. In response to this request, Schmais was contacted by the Experimental and Special Training Branch of NIMH's Division of Manpower and Training Program. She was requested to design a prototypical dance therapy training program on the Master's level. In 1970, Schmais, White, and Davis wrote the grant proposal for Hunter College.

In planning the program, they utilized their own combined experiences in dance therapy practice, training, and movement research to develop an intensive, full-time, 30-credit program consisting of coursework continuously integrated with field experience. (At that time all field experience was planned for Bronx State Hospital.) They also investigated other training programs in the field of mental health, and consulted with many interested professionals, including faculty members at Hunter College and personnel at Bronx State Hospital.

In developing the program Schmais and White kept in mind the needs of the profession. Educational standards were necessary to protect the public from incompetent practitioners, to protect students from inadequate education and training, and to develop criteria for employment, for example, civil service lines on the local, state, and federal levels.

In accordance with the philosophy of dance therapy training on which the program was based, movement observation, which included effort/shape, became a part of the required curriculum of the dance therapy Master's program at Hunter College, and remains so today. LMA continues to be an important part of the dance therapy training programs at Bronx State Hospital as well, and today is taught at most of the dance therapy graduate programs (Goucher College, New York University, Antioch-East).

LMA As A Dance Therapy Tool

Schmais and White developed ways of using LMA as a tool for self-observation, providing a means for dance therapists to analyze their own movement patterns and identify their movement prejudices and preferences. This is equivalent to the need for a psychotherapist to know his/her own emotional repertoire, preferences, and needs, so as not to unconsciously influence clients or overemphasize certain aspects of their needs while possible ignoring others. This concept, frequently referred to as counter transference, becomees particularly relevant in connection to the "therapeutic movement relationship," an essential part of the Chace approach.

In this relationship, the intimacy and immediacy of the movement interaction style of the dance therapist is especially important and difficult to monitor. Since the essence of the therapeutic movement relationship is the dance therapist's ability to react and interact spontaneously with the patient through the medium of dance and movement, it is essential that the therapist have practice in many movement possibilities, including knowledge and understanding of his/her own conflicts about different movement styles. In this connection, the study of LMA can help the dance therapist learn about his/her own movement preferences and prejudices and expand his/her own movement repertoire. It can also aid in understanding the meanings and impact behind the subtlest of communications that take place between patient and therapist.

Often a dance therapist's movement training includes choreography, performing experience, as well as a broad spectrum of movement styles. Many dance therapists, through their intense dance training, have already struggled through certain problems regarding movement preferences, strengths, and weaknesses; hence, a certain degree of self-awareness and body-awareness has been developed. According to White (1987, p.c.), "if the dance therapist receives a solid dance/movement training at the age appropriate time, 'movement thinking' is internalized."[1]

However, for some dance therapists with extensive dance backgrounds, LMA can serve as an accessible and efficient cognitive tool for organizing what is already known and integrated on a body level. In other words, the Laban system of movement analysis can help the dancer/dance therapist to make the transition from an internalized kinesthetic sense to an intricate cognitive understanding of fluctuations in movement behavior. Having access to this body of knowledge allows the dance therapist to record and process minute fluctuations in movement repertoires. In this respect, LMA is a valuable tool for planning treatment goals and augmenting diagnostic impressions of patients.

The contributions of Schmais and White toward the development of Laban Movement Analysis into a training tool for dance therapists marked a major attempt at professionalizing the discipline of dance therapy as well as developing dance therapy into a unique, complete, and documentable method of psychotherapy. What differentiated this method of psychotherapy from other methods was its idiom—body movement. In short, the medium was movement in the form of dance action, and the system for observing and recording interaction, process, and change was Laban Movement Analysis.

Elissa White remained at Bronx State Hospital until 1977. Since then she has been practicing dance therapy and supervising graduate dance therapists privately and is coordinator of dance therapy at the Sound Shore Community Mental Health Center in New Rochelle, New York. Since 1971, she has been teaching courses in dance therapy and in LMA at Hunter College in the Dance/Movement Therapy Master's program she helped create with Schmais and Davis. Claire Schmais is presently the coordinator of the Hunter College program, and has been teaching and supervising dance therapy interns there since 1970. The program at Hunter College is now a 60-credit Master's program with field placements throughout the five boroughs of New York City. Schmais also taught the first dance therapy graduate level course at New York Unversity, and has taught elsewhere on the east coast and abroad. In addition, she has a private dance therapy practice in New York. Martha Davis is presently a well-known and respected clinical psychologist, author, movement researcher, and founder of the former Institute of Non-Verbal Communication Research in New York City. She continues to be a major proponent of LMA as a research, diagnostic, and assessment tool in psychotherapy, and remains a strong believer in the beneficial effects of dance therapy as an agent for behavioral change.

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[1] This may help us to understand how the six pioneering dance therapists developed their work in dance therapy without the additional resource of LMA. For example, Marian Chace, Blanche Evan and Liljan Espenak were all thoroughly trained in the dynamics of dance in addition to the kinesiological aspects of body movement.

Today, Bronx State Hospital (now known as Bronx Psychiatric Center) continues to be a major training ground not only for dance therapists but also for music, art, and drama therapists. The LMA/Dance Therapy Bronx State tradition continues today under the direction of Miriam Roskin Berger, a former student of Bartenieff, of Chace, and of the Midwest pioneer Rhoda Winter Russell. Berger was part of the Zeitgeist at Bronx State, arriving there in the late 1960's. Today, she conducts a training program for Hunter College and New York University graduate students at the Bronx Psychiatric Center, and is the director of their Creative Arts Therapy department.

12

Marion North

Marion North, a protege of Laban and one of the leading dance therapists in England, has made several important contributions to the practice of dance therapy. Her work typifies the clinical use by English dance therapists of Laban's terminology as a tool to diagnose, assess, and plan treatment programs for patients. As mentioned previously, this reliance on Laban's movement framework as a guide for dance therapists is an integral part of dance therapy in England. This is in contrast to dance therapy in the United States, where other theoretical frameworks such as psychoanalytic, ego-psychological, humanistic, and Gestalt Therapy are often utilized in addition to Laban's concepts.

North views dance therapy primarily as an adjunctive therapy. She sees as ideal the integration of several forms of therapy, stressing the importance of combining movement work with other types of psychological intervention—whether it be in other creative arts (art and music therapy) or in the form of psychiatric or psychological treatment.

A major theme that underlies much of North's work is the interrelationship between movement, behavior, and personality adjustment. She views Laban Movement Analysis as a complex and comprehensive theory of movement which can be used to assess personality in regard to its strength, potential, and limitations, as well as to formulate body movement treatment goals.

North stresses that the strength of movement therapy is in its ability to meet the individual at his/her own level of development, and that each individual's modes of expression and adaptation are unique. Hence, she attempts to guide the individual by using what she sees in his/her movement repertoire as the building blocks for further development, integration and modification.

> I see the special value of movement as a therapy, in that it can assist the psychological and physical growth of a child according to the stage of development which he has reached, it can help the gradual unfolding process of differentiation and self-realisation, according to his own capacity. The aim is not toward any "ideal" or "average" person, and therefore there is no "norm." (1972, p. 229)

Implied in the above statement is the concept of the infinite variety and complexity of movement possibilities which is basic to the Laban, Bartenieff, and North philosophies. Both

North and Bartenieff stress that each individual's movement patterns must be seen in their total complexity without preconceived ideas of good or bad movement styles. North emphasizes the importance of noting the individual's movement "needs" (1972), but at the same time she reminds us that movement aspects in reality cannot be dissected and worked on in isolation.

> It is essential to aim for a whole and coordinated movement pattern, rather than to pinpoint a deficiency or disbalance and work on that; indeed, this may well cause a rebound into a deeper state of distress. (1972, p. 41)

Like Bartenieff, North tries to not lose sight of the whole person. All movement aspects, she believes, "are interrelated, and therefore as one aspect changes, the whole balance is different, and a new situation arises" (1972, p. 159).

North's stress on the whole person, as well as her recognition of the complexity and uniqueness of each individual's movement style, demonstrate her sensitivity to the individual's particular struggle on both an intrapersonal and interpersonal level. In her assessments she looks at the individual and observes his/her interactions in both the expressive and adaptive aspects of his/her movement repertoire (1972). However, she continually reminds us that the assessments she makes and the movement prescriptions which they produce are not to be fed back to the patient like a prescription.

> Every human being reacts in his own way to the challenges of life, and is in a state of continual change . . . Movement therapy is an artistic medium, and, as all therapy, needs an experienced and sensitive therapist, able to guide when necessary, and able to leave alone when necessary. Although there are basic principles which should be understood, no set system of rules is given which should be followed. (1972, p. 229)

In contrast to Bartenieff, who began with a pure movement knowledge, North makes the jump from a movement base to personality concepts. In order to verify her belief in the psychological value of LMA as an assessment tool, she attempted to correlate movement characteristics of children with personality traits. She conducted a study, described in her book *Personality Assessment Through Movement* (1972), in which she observed the movement of 12 children over a period of two school terms. Through her movement observations, she deduced certain personality characteristics using effort/shape and behavioral concepts. She then compared her movement analysis of these children with a report on the behavior and personality of the same children compiled by their school teacher and derived in part from the results of the Children's Apperception Test, an I.Q. Test, and a questionnaire depicting certain personality and behavioral characteristics. She discovered a particularly high correlation between her own assessments and the teacher's reports.

Through her study, North demonstrates the value of Laban Movement Analysis not only as an objective, nonjudgmental system to scientifically describe movement behavior, but also as a way to correlate various movement tendencies described in LMA terminology with personality characteristics, including the strength, potential, and limitations of the personality. She concludes that through her study "a fair case has been made out for the accuracy of [personality] assessment through movement" (1973, p. 229).

There is little scientific evidence for the correlations that North makes beyond this initial study. Some dance therapists have expressed concern about overinterpreting movement and thus introducing an element of judgment into movement analysis. We can only speculate, as North did, that certain movement patterns are indicative of certain personality traits, much as we accept without scientific proof the existence of an id, ego, and superego because clinical experience indicates their presence. In light of this, North's study represents a preliminary attempt to depict personality traits and coping styles through the concreteness of movement behavior, and is thus an important step toward developing a psychology of movement. As will be shown later, Kestenberg also conducted a study attempting to concretize accepted psychoanalytic theory through the minute notation of complex movement characteristics.

As has been shown, North's stress is on personality assessment and body movement treatment goals. She does not go into depth in the area of dance therapy practice or outline any single approach or methodology. However, some of the particular methods she uses and their relation to her philosophy of movement are illustrated in the following case study. In this study North relates, through a movement vocabulary, a treatment plan for a 34-year-old female patient who was seen by North for three years, from 1960 to 1963.

This patient, who will be referred to as J., was suffering greatly with intense feelings of deadness, negativity, remoteness, and unreality, compounded by intense fears to the point of phobias. She felt stuck inside herself and wanted desperately to get out.

In her movement description of this patient, North notes that she looked fairly healthy with no severe restrictions or physical deformities. There was mobility in the center of her body but a lack of integration or connection between the movements of the upper and lower body parts. There was pronounced tension in the shoulder girdle and top of the spine, but there was mobility in the joints. J.'s hips were narrowly held, with a lack of the necessary tension that usually helps in keeping balance, especially when moving away from symmetrical alignment. She kept her hands in a closed position, though not bound.

In the movement sessions, North's first goal was to establish the client's trust in the therapist. North believes that therapy "is a cooperative effort, guided by the patient or the therapist at different times" (1972, p. 109).

In beginning with this patient, North felt it important to suggest movement sequences simple enough to master but hard enough to provide a challenge. She used a highly directive approach, suggesting a movement sequence which directly confronted or engaged the conflict J. experienced over her tendency to go "inside herself" rather than "getting out."

> A strict pattern was therefore chosen, one which gave room both for some immediate achievement, and some obvious failure . . . [The pattern chosen was] gathering in—a grasping, closing movement, contrasted with a scattering, opening movement. This was taken in the hands, the upper part of the body and finally with the whole body, including a shift in weight. (1972, p. 109)

In this case, she chose a movement sequence that alternated between a gathering/grasping action and a scattering action. She carefully broke down these opposing actions by encouraging only the use of the hands at first, and then gradually moving to the whole body. In this way, she attempted to help the patient build movement links between opposing drive tendencies in the personality. This is illustrated in North's response to J.'s comment that she "ought to try very hard to be 'out' . . . [referring to her movement choices] and not enjoy the inward movement" 1972, p. 109). North explained:

> . . . this was not the object of the movement [exercise]—. . . all of us are "inside" at some time and . . . it is a normal and, indeed, desirable attribute, but what we wanted her to find was her way or route between the natural inward and outward experience. The route between, i.e., the movement itself, as distinct from a static state, was at this time the most important. This understanding helped the patient not to concentrate exclusively on the opposite side to the one she was experiencing: this would have been unhelpful and probably cause an even stronger rebound into her own inward escape. (1972, pp. 109–110)

It should be pointed out that in this particular case the client stated her problem by discussing her opposing drives, and thus gave North permission to begin the exploration of these opposites.

One has the sense in North's work that she closely monitors the movement experiences which the client is having. She discusses the movement experience with the patient as if it were a joint task of shaping, forming, and deciding with the patient the thoughts, feelings, and experiences of each movement sequence the patient is practicing.

> Each session demands acute observation of the subtle differences and developments, and quick adjustment to the constantly changing situation: a mixture of encouragement at the right time and place, comments on aspects unachieved, and illustrating new implications and tasks. (1972, p. 109)

The philosophy which comes through over and over again in North's work is one of going with a patient's patterns of movement from the point where they begin and then gradually adding, altering, modifying, and extending movement sequences. In other words, instead of rejecting the original movement patterns of the patient, she tries to use those patterns to build new sequences.

A second and unique aspect of North's work is her stress on building and practicing movement sequences. Patients are encouraged to practice what they experience and are taught in the sessions. North believes that altering the patient's movement sequencing behavior can directly affect his/her habitual patterns of response. "To perform the movement, wholeheartedly, concentration is required, and the close relationship between the movement and the inner feelings and attitudes works in a very direct way on the personality" (1972, p. 110).

In addition to her work with movement sequences, North also works with patients in a fashion that attempts to combine held positions with transition movements. She first has the patient practice certain positions which the patient is instructed to hold in space. After the position is mastered, the pathways or transitional sequences which lead from one to the next are experienced and practiced. In deciding on these positions and transitions, North employs the movement language and definitions of Rudolf Laban. The sequences which North instructed J. to follow were:

a) a rising, lifting movement to high;
b) an advancing, extending movement forward;
c) a closing, covering movement backward and down; and
d) an opening, spreading sideways. (1972, p. 110)

North describes a moment of great satisfaction and achievement for this patient. As she did the first transition, a rising, lifting movement to high, she experienced the movement traveling through the center of her body, thus connecting, for the first time, the upper and lower parts of her body. She also commented on a new sensation of experiencing the ground beneath her feet.

At first glance, it might appear as though North's work emphasizes prescribed movement programs as a way to influence personality change. However, not all of her work is done with as much structuring as was the case with J. North did encourage J. to create her own movement sequences but J. was not ready. The directive intervention style that North used with this patient is being stressed here in that it is one clear way in which she has integrated Laban's work into a psychomotor therapy.

An analysis of North's writing and examination of other case studies reveal that her use of effort/shape to plan treatment programs served as a guideline which was not to be followed rigidly. She stresses the need to take into account not only the unique movement patterns of patients but also their personal needs and life circumstances. This more flexible philosophy is also demonstrated in her emphasis on the patient/therapist interaction and relationship.

Summary

North was a dance therapist who correlated personality assessment through movement analysis with psychological and behavioral assessments, and played a significant role in emphasizing the clinical attributes of Laban Movement Analysis. These clinical attributes were further explored and crystallized by Elissa White, Claire Schmais, Martha Davis, Forrestine Paulay, and Judith Kestenberg, and are the focus of the following sections.

13

KMP and Dance Therapy

The organization of concepts borrowed from the work of Rudolf Laban and Warren Lamb into a theory of development, and the application of this theory to dance therapy, was advanced by the work of Dr. Judith Kestenberg, a psychiatrist and psychoanalyst. Although her work includes training dance therapists in her theories and methods, Kestenberg does not have a background in dance and does not call herself a dance therapist, but rather a "movement retrainer." Her work, however, represents a distinct orientation to dance therapy practice and movement analysis.

Kestenberg's work grew out of her long-term collaboration with the Sands Point Child Development Research (CDR) team.[1] Based in part on the theoretical formulations of Laban and Lamb, Kestenberg expanded on LMA, adding subsystems of movement patterns to Effort/Shape patterns and correlating all movement characteristics with psychological phenomena, creating a developmentally and psychologically coherent profile. More specifically, the Kestenberg system views minute, subtle variations of body movement patterns, rhythms, and preferences with regard to their relevance to psycho-sexual stages of development, affects, defenses adaptive functioning, and self and object representations. These are then correlated with the developmental assessment work of Anna Freud (1965). Kestenberg's theoretical formulations also incorporate the work of Hartmann, Winnicott, Mahler, and others.

Kestenberg's integration of LMA concepts with psychoanalytic theory culminated in the formulation of a diagnostic movement profile which measures psychomotor development. This profile, known today as the Kestenberg Movement Profile (KMP) is a complex series of graphs which chart several aspects of a child's movement repertoire using primarily the Effort/Shape movement descriptive vocabulary. These movement characteristics are then correlated within the psychoanalytic developmental framework.[2]

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[1] The other members of the CDR group at that time were Dr. Jay Barlowe, Arnhilt Buelte, Dr. Hershey Marcus and Dr. Esther Robbins. Martha Soodak, joined in 1969.

[2] A complete and definitive description of the work of Kestenberg and the Sands Point Team can be found in *The Role of Movement Patterns in Development 2* (Kestenberg and Sossin, 1979).

The Use of Kestenberg's Work in Dance Therapy

The clinical implications of Kestenberg's work, that is, the concretizing of psychoanalytic thought through the study of body movement patterns, serves as a theoretical foundation supportive of and immediately applicable to the practice of dance therapy. Several of today's dance therapists who have been trained extensively in Kestenberg's work have made contributions in this direction.

Martha Soodak, who was formerly on the board of the Sands Point CDR team and is also in the Academy of Registered Dance Therapists, has used this approach in her practice since 1973. Soodak, a dancer, began using dance in 1951 for therapeutic ends with children. She met Kestenberg at the Dance Notation Bureau in 1969, and this resulted in an association that centered on the therapeutic aspects of expressive movement and movement training. Presently, Soodak works as a dance therapist in collaboration with Dr. Esther Robbins in New York.

Concerning her use of the KMP, Soodak states:

> Although a person well trained in movement has in mind a rather complete concept of the range of human capacity, it is very useful to have a structure which describes, defines, and analyzes this, taking it from the realm of intuition into that of objectivity. The profile . . . serves as a framework for orientation. It provides terminology for defining and interpreting movement events which arise during the therapy, and at the same time, it places them into a developmental context. So, the therapist can see what the patient's strengths and weaknesses are, what [strengths] need to be shored up, what can be safely worked with, and what should be deftly sidestepped. . . .

Soodak continues:

> During the course of my work, I have . . . observed fixed characteristics of holding or moving which I term 'body defenses'. The use of the profile terminology promotes accurate description of such defenses. . . .
>
> In working to correct these distortions, I keep in mind that while defenses may be counterproductive, they serve . . . to keep a person functional. Thus . . . I do not immediately seek to remove patterns, but rather to build in the [patients'] capacity to support alternative ways of doing things. Only when it is clear that the patient has the capacity to support movement without the undesirable habits, do I address it directly. . . . (Soodak, 1986, p.c.)

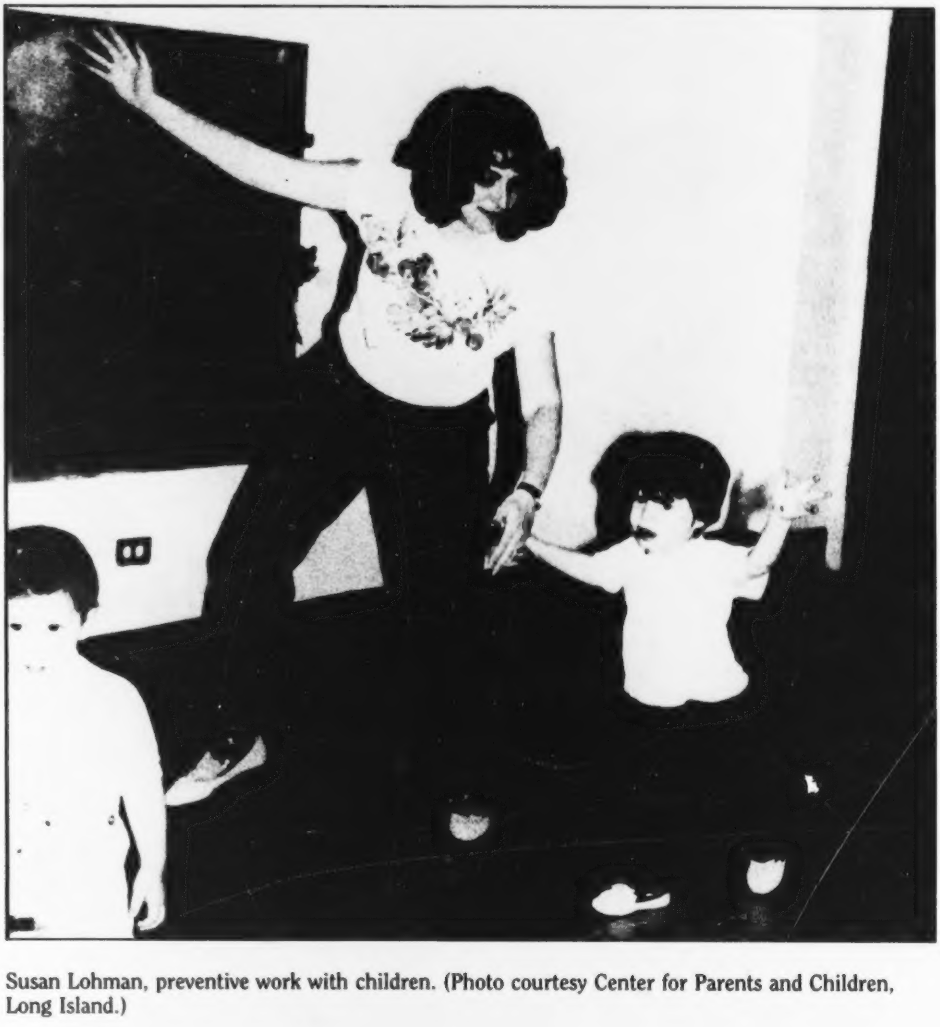
Another dance therapist trained in Kestenberg's work is Penny Lewis (formerly known as Bernstein), author, educator, and founder of the Dance Therapy Master's Program at Antioch New England College and the Dance Therapy Master's Specialty at Goddard College. Lewis has been a leader in her adaptation of the Kestenberg System to the clinical and research needs of the dance therapist. In her article "Recapitulation of Ontogeny: A Theoretical Approach to Dance/Movement Therapy," Lewis (Bernstein, 1973) discusses the importance of establishing a theoretical framework for the practice of dance therapy. She cites aspects of Kestenberg's movement framework and discusses it using concepts of functional and adaptive behavior versus dysfunctional, maladaptive behavior. She believes that through the observation of one's movement patterns, adaptive versus maladaptive behavior can be diagnosed, as can the developmental level of the patient and hence, his/her movement needs. She gives examples of adaptive/functional movement patterns for each of Kestenberg's developmental categories and juxtaposes this with its maladaptive/dysfunctional counterpart.

Susan Loman, Director of the Dance Movement Therapy Department of Antioch New England Graduate School and former student of Lewis, went on to receive extensive training with Kestenberg and has been working in collaboration with her since the late 1970's. Loman uses the profile as an assessment and intervention tool in her prevention work with infants, children, parents, and families at the Center for Parents and Children, co-directed by Judith Kestenberg and Arnhilt Buelte, Long Island. She has also been teaching Kestenberg's work at the Laban/Bartenieff Institute and elsewhere, and has done research using the KMP.

Susan Lohman, preventive work with children. (Photo courtesy Center for Parents and Children, Long Island.)

One application of the profile which Loman finds helpful in preventive work is "attunement," a concept which is comparable to kinesthetic empathy. The infant or young child feels comforted by those whose movement patterns "attune" to his and thwarted by those whose movement patterns "clash" with his.

In each phase of a child's development, different rhythms become prominent and necessary for the child's successful mastery of developmental tasks. When the parenting figure is unable to adapt his/her personal movement preferences to synchronize and/or harmonize (both forms of kinesthetic empathy) with the child's, the child may become hampered in his/her psychodynamic growth.



Susan Lohman, preventive work with children. (Photo courtesy Center for Parents and Children, Long Island.)

In her work at the center, Loman trains interns to detect, with the help of the KMP, "clashing" movement patterns between child and adult, and to recognize maladaptive movement styles in the child as a result of these clashes. Once the above is analyzed, the dance therapist is able to "attune" to the child's and adult's movement patterns and in this way begin the process of promoting healthy functioning and making up for early deficits and frustrations. Parents are also helped to move more synchronously and comfortably with their children, that is, to attune to their children.

In this respect, Loman compares aspects of the work to Winnicott's (1965) "holding environment". This concept which is so often referred to as "starting where the patient is," pervades the dance therapy literature. After "attunement" is established between therapist and patient, the dance therapist can begin to facilitate the development of new adaptive and expressive movement patterns to eventually replace destructive, maladaptive and repressive behaviors. Various games, tasks, movement interactions, images, props, tactile stimulation and other dance therapy techniques are specifically designed to stimulate new forms of interaction, coping, and self-expression. All of these interventions are based on the findings of the profile.

At the Center, dance therapists work either with the child or adult alone, or with the parent and child together. During sessions dance therapists try to "foster greater empathy between parent and child through their movement interactions, to remove obstacles to developmental progression and to strengthen the child's resources" (Loman, 1981, p. 2). The interventions used at the center span the entire range of dance therapy methodology discussed thus far. What primarily differentiates the Kestenberg approach is its emphasis on prevention and the use of the profile as a guide to treatment.

In her 1981 presentation for the ADTA, Loman noted that the principles from the profile can be incorporated by dance therapists without necessarily constructing a complete profile, a process which is extremely time-consuming. In this regard Loman stated, "A dance therapist with knowledge of [and training in] the profile can still apply its principles to her work with clients even if a complete profile is not constructed" (1981, p. 5).

Although these and other leaders are utilizing Kestenberg's theories in their clinical practices, and although dance therapists continue to be trained in the Kestenberg theoretical framework, there is little written to date that comprehensively integrates the profile with the practice of dance therapy. This would be a valuable contribution to the field.

Discussion

LMA: Varying Views

While the practical applications of Laban Movement Analysis vary greatly among those dance therapists who incorporate it directly into their work, there are, generally speaking, two major views concerning its function and use in the field today.

One school of thought is represented by the views of Elissa White, whose work was discussed earlier. In review, White emphasizes LMA as a *tool* that can be used by dance therapists in the following ways: to record patients' movement dynamics; to provide a format for developing treatment plans; to analyze patient/therapist interaction; to develop the dance therapist's ability to observe his/her self; and for research.

Virginia Reed is a leader in the integration of Laban's work with the theory and practice of dance therapy. A certified movement analyst, she was a close friend and colleague of Bartenieff. For Reed, Laban's work is a psychotherapeutic philosophy and a dance therapy methodology in and of itself. Reed emphasized LMA as an integration of a philosophical, anthropological, psychological and physiological view of life. She believes that inherent within this system is a therapeutic philosophy that sees life as a continually developing, growing, and changing process. Several other dance therapists certified in LMA, including Monica Meehan McNamara, Cece Ritter Flax, and Bonnie Robbins, are working to further explore this holistic concept of Laban's work.

Diana Levy (1987, p.c.), the first Dean of the Certification Program in LMA at the Laban Bartenieff Institute, sums up this school of thought in the following statement: "My experience teaching LMA for many years has led me to believe that personal integration of those concepts which are most fundamental to the LMA framework *is* a therapeutic process."

SECTION B

Further Expansion of Dance Therapy Theory and Practice

14

The Evolution of East Coast Influences

As Laban's theories were influencing dance therapy during the late 1960's and 1970's, some dance therapists were also beginning to encorporate psychanalytic concepts into their work. This chapter discusses the contributions of Elaine Siegel and Zoë Avstreih, two leaders in this area. Their work provides a general overview of the psychoanalytic concepts that Siegel and other dance therapists began espousing in the late 1960's, which today are becoming an important part of the dance therapy literature.

Elaine Siegel

Author of the book *The Mirror of Our Selves: A Study in Dance-Movement Therapy* (1981), Elaine Siegel completed a dance therapy training program with Espenak in 1964. Her dance background includes training in classical ballet and in Haitian and African primitive dance. To broaden and clarify her understanding of personality with special concern for how the psyche and soma interact, Siegel turned to the study of psychoanalytic thought, and completed two training programs in psychotherapy and psychoanalysis.

Seigel has integrated her psychoanalytic knowledge with her understanding of body movement and psychotherapeutic treatment. In her article "Psychoanalytic Thought and Methodology in Dance-Movement Therapy" (1974), Siegel points out one essential difference between the psychoanalytic model of therapy and dance therapy. This difference centers on the issue of verbalization versus somatization. She states:

> The psychoanalyst . . . is firmly convinced that "somatization" ideally should be a minimum and confined to "trial action" within the psychic structure so that the ego can then decide what action to take in the real world. (1974, p. 29)

In contrast, the dance therapist is frequently encouraging the physical expression of emotion on various levels.

Having pointed out this seemingly broad rift between psychoanalytic treatment and dance/movement treatment, Siegel then points to the similarities. She states:

> First and foremost, both therapies are essentially developmental in nature, expecting the client to grow out of an inefficient, fixated or infantile mode of existing into a nearly normal one. (1974, p. 30).

Siegel also refers to the significance of the transference relationship as instrumental in the growth of the client in the dance/movement therapy situation. Like many of the original pioneers, she refers to the parallel between improvisation in dance therapy and verbal free association in psychoanalytic treatment, noting that both methods of exploration work to release unconscious thoughts, feelings, and associations.

> Depending on the state of treatment, the dance-movement therapist may then lend herself as a catalyst to a cathartic reaction or interpret via dance movement and verbalization, much like an analyst who hears, reconstructs and interprets the patient's past from verbal remembering and the observation of affect states. (1974, p. 30)

Siegel emphasizes that different populations require different kinds of movement intervention. In addition, what the dance therapist can do with a patient who is seen privately several times a week cannot be done in weekly sessions in a hospital setting. Whereas Siegel sees movement therapy as a form of treatment which can, through the positive transference relationship, help an individual regress to the fixation point and hence work through previously unresolved conflicts, she does not see this as feasible or advisable in the usual hospital setting or for all patients. For example, Siegel cites the autistic child[1] who never advanced beyond the very early stages of development and who is still attached or merged with the mother. "He needs another chance to live through the body-image building stages of the mother-child dyad" (1974, p. 30). In such a case, the patient is already in a state of regression and the focus of the dance therapist must be on building in the awareness of self and others. This can include holding, touching, breathing together, and so on: activities not usually appropriate for the neurotic client. Similarly, while Siegel sees the therapeutic movement relationship as one way of fulfilling early childhood needs, she also works as an empathic observer with the neurotic client who can benefit from more independent work and free association during improvisations.

Siegel encourages the dance therapist's respect for the uniqueness of individual psychomotor expression. She believes that the individual's personality cannot be separated from the cultural influences that helped to shape and form it. Thus, an individual's movement is reflective of both inner impulses and outside influences, as the latter give external form and shape to the former. As a result, external forms such as ballet, modern dance, or flamenco dance can become authentic expressions of the self if the individual in earlier years cathected to these particular styles through visual and/or bodily experiences and attached unconscious significance to them.

In this respect, Siegel's view of body movement is contrary to Whitehouse's view that "authentic movement" comes directly from the unconscious with no structuring from cultural influences, and seems to coincide more with the belief that "all movement is authentic" (Kalish-Weiss, 1980, p.c.). Siegel believes that the concept of "authentic movement" places expectations on the patient to express him/herself in a specific way. For Siegel, no single methodology or movement form is appropriate for all individuals. Each individual is the result of a complex interrelationship of early experiences and memories. The therapist must be able to perceive, respect, and appreciate this complexity in order to find the appropriate and meaningful style of intervention for each individual.

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[1] Siegel's work with children is discussed in Chapter 18.

One can see how Siegel's earlier experiences with both the extreme intellectual control of ballet and the pure emotional discharge of primitive dance have led to her belief in the need to find a constructive and meaningful balance and integration of conscious and unconscious influences. Siegel does not attend only to the unconscious aspects of the personality, but is equally concerned with preserving and developing the ego functions of the individual. In this respect, she is aligned with the thinking of the ego psychologists, who stress the integration of the unconscious with the conscious aspects of development. Whereas Siegel sees Haitian and primitive dance as expressions of the unconscious, she sees ballet as potentially the expression of the patient's ego-ideal, that is, when used correctly, but warns that it also has the potential of being the expression of the punitive superego if introduced anatomically and psychologically incorrectly (Siegel, 1980, p.c.).

Siegel believes in Hartmann's concept of working in the conflict-free ego sphere (Siegel, 1974, 1980), and building the individual's adaptive resources. The defenses of the individual as manifested in bodily actions will dissolve, Siegel contends, when enough ego strength has been encouraged and successful therapist/patient contact made. However, she cautions that this should not be pushed or encouraged prematurely (1980, p.c.).

Siegel notes that a close examination of Chace's writing reveals continual references to the concept of meeting the individual on his/her level of development and readiness for interaction and communication (Siegel, 1980, p.c.). Siegel believes that Chace, in picking up on the patient's movements, is accentuating the ego by making contact with the patient within the conflict-free ego sphere, hence broadening and expanding the healthy and adaptive aspects of the patient's total functioning. She contrasts this with other mental health disciplines whose emphasis is on illness and on constant interpretation of pathology.

In her work, Siegel differentiates between catharsis and abreaction. She sees catharsis as a part of therapy but not its goal. "Catharsis, with its emphasis on the temporary absence of ego and conscious thought, can be either too frightening or addictive" (1979, p. 90); whereas the psychoanalytic concept of abreaction Siegel views as a potentially more gradual process of letting go. Abreaction supports the active presence of the observing ego, hence allowing previously repressed thoughts and feelings to gradually emerge and become integrated into the existing ego structure.

Along similar lines Siegel stresses seeing the patient as a whole, implying the integration of the unconscious with the conscious. She emphasizes the importance of verbalization as integration of the nonverbal expression, again placing stress on the whole person with utilization of all his/her strengths and abilities. In conjunction with the need for verbalization and interpretation, Siegel notes that movement can at times be a defense against one's thoughts and feelings. The dance therapist must therefore be on the alert for when to encourage and when to discourage the patient's use of movement.

Finally, Siegel, though dedicated to dance, prefers the word "movement" in describing her work, since the term "'movement therapy' includes all forms of moving one might employ with any kind of patient during a given session" (1979, p. 92). This can include holding a patient, breathing with an autistic child, and other early steps which she believes build the ego strengths of the patient and hence prepare him/her for more dance-like activities. In short, the word "movement" covers a broad spectrum of styles and levels of body movement participation and intervention.

Many aspects of Siegel's methodology overlap with that of other dance therapists discussed so far. Her work synthesizes, modifies, and refines many of the original contributions of the pioneers. An overview of her methodology reveals the use of exaggeration of movement styles for the purpose of reality-testing, exploring the unconscious meanings of actions and intensifying bodily felt experiences and emotions. She also uses mirroring and the movement interactional dialogue as well as the patient's self-touch and touch of therapist to help in developing a sense of boundaries in moments of more severe regression. Siegel believes in discussing and interpreting movement events and behavior. Stress on interpretation is determined by the particular needs of the patient. She works with and without music and moves on a continuum, from the use of balletic expercises to help patients construct images and movement themes, to pure improvisation or sitting with and rocking a schizophrenic child. In essence, it appears that for Siegel, first and foremost are the client's needs. Though she views these needs in formal psychoanalytic terminology, her interaction with patients can best be characterized as flexible and reflective of the moment.

Zoë Avstreih

Zoë Avstreih, former Coordinator of the Graduate Dance Therapy Program at Pratt Institute, is a psychoanalyst and dance therapist. Like Siegel, she has been deeply influenced by her psychoanalytic training, specifically in the area of object relations theory and self-psychology. In dance therapy, Avstreih was trained by Claire Schmais, Elissa White, Elaine Siegel, and Blanche Evan.

In "The Emerging Self: Psychoanalytic Concepts of Self Development and Their Implications for Dance Therapy" (1979), a paper presented at the 1979 Annual American Dance Therapy Association Conference, Avstreih presented clinical studies in which she analyzed the psychodynamic needs of five patients and described the therapeutic movement intervention styles she used to meet each patient within his/her developmental level. Avstreih's approach centers on the developmental process, using Mahler's concept of separation/individuation as a base. She emphasizes the importance of the transition from contact perception to distance perception, and finally to spatial organization. She states: "The need for contact perception versus distance perception and the ability to sense oneself and others as continuous in space reflects the degree of separation achieved" (1979, p. 7). In this connection, it is particularly important for the dance therapist to determine the most appropriate distance for establishing contact with the patient. Depending on the patient's level of development, too much closeness might be perceived as engulfing while too much distance could be perceived as abandoning.

Avstreih incorporates into her theoretical framework Winnicott's (1958) concepts of the "Holding Environment," the "Primary Illusion," and the "Good-Enough Mother." The "Holding Environment" defines the child's inner and outer worlds. Through the mother's "empathic, non-intrusive holding" (1979, p. 3), or lack of it, the child develops either a sense of self-worth or of emptiness. If the mother is empathically attuned to her child's needs, the child will come to believe that he is creating what he needs. This is what Winnicott calls the "Primary Illusion," that is, the illusion of self-sufficiency. This provides a sense of security and is important in the child's later development of the ability to love and care for others.

The "Good-Enough Mother" through her nurturing, reflects to the child his feelings about himself. "If she is not able to reflect accurately the child's affective states," Avstreih says, "he will not be able to develop a reliable sense of self" (1979, p. 5). Thus, if the sense of self has been blocked by a "non-responsive, non-empathetic" maternal figure, the dance therapist can fulfill this role by providing a reflective image. Through her own unique and direct use of self, the dance therapist can help to reconstruct any missing aspects of the child's early developmental experiences, and hence, to reintegrate the body image of the child.

The dance therapist works within what Winnicott (1958) has called the "transitional space." Belonging neither to external reality nor to the individual's internal reality, the transitional space, according to Avstreih, ". . . is the space of therapy. It is here we help to build the bridge which connects and separates the inner with the outer and the self with the object" (1979, p. 22). It is in the transitional space, Avstreih says, that ". . . the psyche of the therapist and patient can play, i.e., join in the spontaneous affective exchanges which were so lacking in the early maternal environments" (1979, p. 7).

This can be illustrated by Avstreih's work with an adult patient named Marcia. Marcia did not feel comfortable with her body and displayed

> . . . a general giving-in-to-gravity . . . and a tendency towards quick, self-related, gestural movement. . . . [She] was hypercathected to her body which led to a great deal of somatization and she felt an overwhelming sense of emptiness and isolation. (1979, p. 9)

Her movements, which were stiff and forced, were intellectually motivated rather than from feeling or experience. Finding the dance studio uncomfortable for its lack of outside stimuli, she kept asking for more structure and exercises. Avstreih, believing that Marcia "lacked the primary educative experience which exists in the mother/child dyad" (1979, p. 10), decided to move with her. Avstreih used her own body as "a mirror to serve as a bridge enabling . . . [Marcia] to rediscover her body parts and gain a sense of mastery over them" (1979, p. 10). Avstreih then structured a play-like situation in which they alternated initiating and joining in movements. As the child begins to develop a stable body image through "reflective interaction with the mother" (1979, p. 10), the adult (in this case, Marcia) who had been deprived of this "feeding" develops a sense of self through interaction with the therapist.

In conclusion, Avstreih's practical extension of the works of Winnicott, Mahler, Spitz, Kohut, Kestenberg, and others has further clarified the contributions of dance therapists such as Chace and Siegel, and has rounded out the overall picture of dance therapy as a form of in-depth psychotherapeutic treatment.

15

The Evolution of West Coast Influences

While many dance therapists, particularly on the east coast, welcomed the introduction of effort/shape and psychoanalytic concepts and incorporated these in varying degrees into their work, others perceived this trend as contrary to the early and major tenets of the field. These dance therapists continued to emphasize a more experiential approach which avoids labeling or diagnosing. This trend was particularly evident among dance therapists on the west coast, especially those who were influenced directly or indirectly by Mary Whitehouse and who generally work with a fairly healthy non-hospitalized population.

This chapter reviews the literary contributions of dance therpaists who, in carrying on the teachings of Whitehouse, have broadened and/or clarified aspects of the Whitehousian approach. Some have focused on the Jungian aspects of Whitehouse's work, and others on "authentic movement" and/or movement experiencing. It should be pointed out that although the discussion focuses on the expansion of Whitehouse's teachings, the influence of the other major west coast pioneers, including Hawkins and Schoop, can also be discerned in some of the writings reviewed below.

Expansion of the Whitehousian Approach: Non-Jungian Aspects

Three dance therapists who have written about their use of non-Jungian aspects of Whitehouse's teachings are Erma Dosamantes-Alperson, Diane Fletcher, and Janet Adler. Their work is representative of an approach which generally stresses inner attending to the body and to body-level experiences and bringing these internal experiences forward into movement. (This is in contrast to the Chacian approach which is more interactional.)

Erma Dosamantes-Alperson

Dosamantes-Alperson, a clinical psychologist as well as dance therapist, contributed numerous articles during the 1970's espousing techniques and theories of what she calls "experiential movement psychotherapy." This refers to a form of therapy which integrates movement, imagery, and verbalization, and incorporates several aspects of the Whitehousian approach.

She prefers the title "movement psychotherapy" to "movement therapy" because she feels the latter can be mistaken for the body therapies which do not incorporate the emotions.

Dosamantes-Alperson was strongly influenced by her dance therapy training with Alma Hawkins and by Whitehouse disciples Joan Chodorow and Janet Adler. She was also influenced by Nikolais in dance and by Gendlin, Perls, Freud, Sullivan, Rogers, and others in psychology. Although she is a clinical psychologist, she does not believe in applying medical labels to the individuals she treats, and basically feels that the difference between the way the dance therapist functions in a psychiatric hospital setting versus in private work is based more on the different demands of the setting itself than on the diagnosis of the individuals seeking treatment.

Dosamantes-Alperson views movement as an excellent device to facilitate the integration of the intuitive-preverbal level of human functioning with the rational-verbal level. Referring to Gendlin (1971), she states:

> Personality change is promoted when a person is able to make contact with a bodily felt level of experiencing . . . and is able to verbalize or make explicit at least some portion of it. (1974a, p. 211)

Referring to Wallen (1970), Dosamantes-Alperson lists three ways that individuals commonly avoid the "bodily-felt level of experiencing": (1) poor perceptual contact with one's body and its environment (i.e., being unaware of what various body parts are doing at any given time); (2) blocking the open expression of an urgent need; and (3) repressing an unacceptable reaction, such as anger. "When we distance ourselves from our experiential body process," Dosamantes-Alperson states, "we literally cut ourselves off from the kinesthetic and sensory input on which we rely to know our various feeling reactions toward ourselves and the world" (1974a, 211). Effective therapy, therefore, must place the patient at the center of his/her own experience.

Dosamantes-Alperson delineates two styles of movement, or two experiential modes: the receptive mode, where attention is focused inward on internal events; and the action mode, where attention is focused on external events. In the receptive mode, the client focuses on internal stimuli, allowing sensations, feelings, images, and thoughts to emerge and flow naturally. Movements in this mode are subtle and often difficult to detect. They are referred to as "shadow movements" or "internal-intrapsychic movements" (1979b, p. 21). Examples include changes in body tension and breath flow. Such movements can be facilitated by having the client lie down with eyes closed. This reduces external stimuli and enables images, memories and associations to emerge.

The receptive mode can be illustrated by the case of Sharon, a 32-year-old woman who complained of breathing problems and tension in the neck and chest areas. Dosamantes-Alperson suggested that she lie down, eyes closed, and focus on the tightness in her chest. Soon Sharon formed an associative image of a block of ice, which began to melt as she concentrated on it. A physical release was observed in her body. "Her chest muscles became relaxed, her breath flowed more smoothly, and tears streamed from her eyes in an automatic way" (Dosamantes-Alperson, 1979b, p. 23). As Sharon permitted herself to relax, she could breathe more deeply, and was able to cry and to verbalize her emotional reaction to the experience.

Images which occur during the receptive mode are referred to as "hypnogogic images." They are "preconscious, preverbal visual symbols characterized by changing thematic content, motion, vividness, affect and relative autonomy" (1979b, p. 25). They allow the client to actually relive situations from the past, merging them with the present. This can lead to new insights into unresolved conflicts. Dosamantes-Alperson states that

> . . . the movement psychotherapist can assist the transformation of the physical form to the visual symbol by first helping clients discriminate the physical or bodily qualities they experience and then encouraging them to allow an image to develop which shares similar attributes to the physically experienced one. (1979b, p. 24)

Then, after the imagery phase, the therapist facilitates physical identification with the image and externalization of the image through movement.

> The value of *moving an image* rather than simply focusing on an image without movement, is that clients can take the visual experience into their bodies, allowing a physical identification to be made between their internal sensations and the imagined situation. They can empathize physically with all aspects of the image and thereby gain an awareness of the attitude they hold toward each revealed experiential element. (1979b, p. 26)

While in the receptive mode the individual's attention is focused inwardly, in the action mode attention is focused outwardly. "When clients move in the action mode," Dosamantes-Alperson says, "they reveal how they approach and deal with the external world of objects and people" (1979b, p. 27).

In this mode, the patient moves with eyes open, moving deliberately and exploring the surrounding space. Movements are "overt and readily detectable." Terms used in this mode are "movement style" or "movement range," and the process is categorized as "external-interactional movement" (1979b, p. 27).

Many clients, especially those without experience in dance or other physical training, will need to become "desensitized" or "disinhibited" before they can move without feeling self-conscious. The therapist can facilitate this by creating a relaxed and conducive atmosphere, which "offers clients the opportunity to discover physical and movement aspects of themselves while providing an opportunity to exercise a safe degree of self-direction" (1979b, p. 27).

The client begins to express his/her personality as he/she moves with more confidence and spontaneity in this mode. There is increased self-awareness as the client learns which types of movement are comfortable and which are uncomfortable and as he/she becomes aware of differences and similarities between his/her movement and that of other group members.

The following case study illustrates the external-interactional mode of movement. Dosamantes-Alperson describes a session which took place on Halloween Eve, in an all women's group. One of the members came dressed as a witch. Because of her dramatic appearance it seemed to Dosamantes-Alperson that "this woman needed to be acknowledged by the group for that part of herself represented by the witch character" (1979b, p. 29).

The client was encouraged to become the center of the group and to express the witch's character through movement. She used expansive, undulating movements, sometimes seductive, sometimes aggressive. She was encouraged by the therapist to move with and relate to each group member individually. This role gave the woman a sense of power and control. The group members, in turn, responded to her:

> Some allowed themselves to be bewitched, letting themselves be overpowered and yielding to her. Others rejected her attempts to overpower them by asserting their own strength against hers. (1979b, pp. 29–30)

The discussion that followed the movement session brought out the feelings the issue of power aroused in each member of the group.

In comparing the receptive mode with the action mode, Dosamantes-Alperson says:

> . . . internal-intrapsychic movement provides a bridge between less conscious and more conscious levels of experiencing and acting. Through external-interactional movement which takes place in the action mode, clients can ascertain how they cope with the external world and the sort of impact they have on the world. (1979b, p. 30)

It appears that movement in the receptive mode is less willed and less overt than movement in the action mode, and can be related to the Whitehouse concept of "I am moved" as well as Hawkins' stress on attending and relaxation. Contrarily, the action mode involves more willed and overt movement and more interactional movement. This can be more closely connected to what Whitehouse called "I move."

In early sessions, Dosamantes-Alperson has her clients work within each of the two modes in order to help them explore their range of movement and increase their awareness of and sensitivity to their own bodies.

As sessions progress, greater usage is made of the person's "imaginative responses" (1974a, p. 212). As the client's movements grow in range, sessions become less dependent upon the external structure imposed by the therapist, and become more self-directed. The therapist then becomes more of an observer than a guide, interceding "only when the client encounters a block in her movement" (1974a, pp. 212–215). Sessions generally last for two hours. At the conclusion, the patient is asked for verbal comment and expression. In this way, the patient connects his/her own words, thoughts, and images to the movement experience.

In summary, in Dosamantes-Alperson's discussion of the receptive mode of movement she is describing west coast ideas growing out of her training with Hawkins and Whitehouse. These ideas center around concepts of attending to the body, bodily felt experiences and felt movement, and the process of connecting these bodily experiences to imagery and finally dance-movement action. On the other hand, when she describes the active movement modality, one detects more of a Schoopian tone. Dosamantes-Alperson's major contribution to contemporary dance therapy has been clarification of the psychotherapeutic process as it pertains to the dance-movement experience.

Diane Fletcher

Fletcher was strongly influenced by her dance therapy training with Whitehouse and Hawkins, and was also trained in the Chacian approach. Like Dosamantes-Alperson, Fletcher's work focuses on the bodily-felt experience, or as Fletcher calls it, the "body experience." In her article “Body Experience Within the Therapeutic Process: A Psychodynamic Orientation” (1979), she states:

> . . . the very process of focusing on body experience tends to draw out the psychological content and the dynamic organization to which the body experiences are linked. Such is the basis of the use of body experience as a means towawrd intrapsychic reorganization. (p. 137)

In Fletcher’s view, internal events are represented physically as sensations, while the body itself is represented mentally as an image or series of images. When psychic disturbance is present, the images may be distorted or blocked. Through intense integrated body experiences, the individual’s distorted body image can be altered, and this, Fletcher believes, is one of the roles of dance therapy.

Fletcher discusses four different aspects of experience. The first is subjective experience, the “immediacy of one’s own perception of self and . . . quality of being” (1979, p. 137). More specifically, subjective experience is the “receptive capacity of allowing into consciousness both sensory data from the external world and internal perceptions such as sensation, image, fantasy and thought” (1979, p. 137). It is important for the dance therapist to discover how the client perceives his/her sense of self (i.e., whether it is localized, non-specific, etc.).

Distortions in perception and experience may occur when parts of the self are fragmented or projected outside the body. These distortive mechanisms are usually not consciously experienced, but they may result in anxiety and a feeling of being lost. Therapy can enrich the capacity to experience through the process of association. “In this process, both physical and mental elements of experience are brought into association with each other and into relation with the self. There is an inner dialogue” (1979, p. 138). Through this association comes the emergence of important patterns.

The second aspect of an experience is identifying and reflecting on its content. One must be able to recognize, concentrate on, and think about what is happening. This process differentiates between internal and external stimuli and reactions. Intellect, reason, and reflection are brought together, and “in this way, the objective and subjective aspects of the self are integrated” (1979, p. 139). Verbalization becomes important in this phase. The experience is broken down, piece by piece, and reorganized into a pattern which the individual is able to deal with on a level of mastery, rather than on a feeling level of being overwhelmed and subjugated.

The third aspect is identifying the actions and/or mechanisms which are used to make an experience happen or prevent it from happening. It refers to “the self as the *doer,*” (1979, p. 139) and “relocates the responsibility and control back inside [the] . . . person so that events do not any more ‘just happen’” (1979, p. 139).

The capacity to modify one’s immediate experience is a survival mechanism, dating back to infancy. “It involves first learning how to distinguish ‘good’ from ‘bad’ and then learning how to organize oneself accordingly” (1979, p. 139). For example, we commonly try to avoid unpleasant sensations or experiences, often through unconscious physical action. Therapy can increase one’s awareness and thus “many . . . defensive motor mechanisms can potentially be brought under more conscious control and the underlying feelings can thereby be more readily tapped” (1979, p. 140).

The fourth aspect of experience in linking, "the process by which the elements of experience are internally connected in meaningful association with each other and organized in a uniquely coherent way" (1979, p. 141). A person comes to know the self and the world by "linking up" various aspects of experience into a meaningful framework. When reality is too painful or overwhelming, the linking process is disrupted. "The internal destruction of these links which connect the various internal signals, associations and sensory impressions result in the destruction or alteration of the perception of reality" (1979, p. 142). Linking up the experiencing, observing, doing, and integrating aspects of the self into an organized whole is the first step toward self-knowledge and freedom of choice.

Fletcher describes her work with Mr. C., a successful professional in his early forties. He expressed feeling inadequate and uncomfortable in relating to others. He felt cut off from his body. Spontaneity was unnatural to him, and he dreaded sinking into an inert state, which he feared was his real self.

As he spoke, Fletcher asked him to become aware of his body and to pay attention to what it was doing. What became apparent was the

> continual and alternating efforts of tightening and pulling in his shoulder, across the chest, arms, and the whole torso . . . fairly small but actually quite effortful tensions that were inhibiting not only any possibility of a more relaxed or easy state, but were constraining and covering any spontaneous motions toward action. (1979, p. 148)

As Mr. C. focused on his body, he could feel the efforts he was making to hold himself back. Once he began to let go of some of the constriction, he experienced twinges of sensation. Gradually, the impulses became more defined. Over several sessions, his movements became larger and more forceful, but still not without constraint. As he bacame more aware of his bound energy, he began to feel frustrated. He no longer wanted refuge in inertness, but he did not know what to do.

With the physical breakthrough, he was able to feel and develop his body experiences. Mental associations were much more difficult. However, Fletcher notes,

> . . . even the very process of having to articulate about his immediate experience was developing in him the capacity to find a language for his inner experiences and helping him to link his subjective experiencing self to his objective observing self. This also helped to develop his capacity to take council with himself and to communicate his inner self to the outside world. (1979, p. 149)

Once Mr. C. was able to identify his behavior, he could begin to experiment with changing it. Further breakthroughs occurred in later sessions. He became more able to use mental imagery, and allowed himself to focus on memories he had previously repressed. Fletcher sums up the case by saying:

> This case illustrates some of the values of focusing on the body and following the cues and impulses so minutely. So much of Mr. C.'s experience was threatening, repressed from consciousness and partially expressed through the body in unconscious behavior and incipient action without being linked to awareness, self-perception or thought. In such a case . . ., when the body information is so divergent from his self-concept, the body experience assists in the process of reclaiming some of what had been repressed. As the

> material was becoming more articulated and linked coherently to image, thought, memory, and emotion, it began to have more meaning. . . . Each new linkage and integration brings about a slightly new constellation from which the next experience emerges. (1979, pp. 153–154)

In generally discussing the therapeutic uses of body experience (not specifically referring to one patient population), Fletcher states that most body oriented techniques can be included in one or more of the following five categories:

1. *Discovery* referring to new experiences; and to increasing and enriching the movement repertoire and range of response. This begins at a very basic level—learning about body parts, sensations, and the different ways in which the body can move. New experiences must take place, and there must be new awareness and new sensory perceptions if there is to be any change.

2. *Reconstitutional body work*—working on the body to help the individual "let go" or "get rid" of anxiety or negative feelings. Relaxation techniques and other forms of anxiety reduction, as well as movements that can express or discharge energy, are often used to facilitate a patient's freer response. Besides the immediate aim of momentary relief, there may also be long term educational goals.

> The goals may be to teach a person how to take care of himself, how to take charge of his condition, handle his anxiety and emotions and to help himself feel better. Such a process may be depicted as being a parent to oneself. (1979, p. 143)

However, Fletcher notes, problems are not necessarily solved simply by releasing tension and negative feelings. If techniques are too abrupt and/or explosive, the highly charged material that is brought up may further disorient the person rather than the opposite. The release process must be coupled with therapeutic work so it may be utilized and integrated fully.

3. *Restructuring*—physical restructuring of movement and posture at a neuromuscular level. These techniques can have the effect of "relieving tension, of reconstitution, and sometimes, of assisting intra-psychic change" (1979, p. 143). However, if the client's body awareness is very limited, such techniques can result in redistortions.

4. *Interpersonal Communication*—using body experience to promote human contact and communication. Fletcher attributes this type of work to Marian Chace, who used it with groups of hospitalized patients. Though this work may include reconstitutional experiences, the stress is on socialization and group interaction. "Movement," Fletcher states, "operates as a medium, like language, by which interpersonal skills and relations can be developed and an initial feeling of self through relating to others can be found" (1979, p.143).

5. *Intra-psychic reorganization through insight into meaning*—using body experience to bring "pre-verbal and undifferentiated experiences" into consciousness, thus resulting in increased understanding of the inner self. The overall goal is an integrated, cohesive union of physical and mental processes.

Fletcher stresses that the therapist must identify which of the above uses of body experience would be most effective for each individual. She states that her focus is

> . . . to use body work for the purposes of discovering new experience, interpersonal communication and intra-psychic reorganization through insight into meaning, though some reconstitutional work may occur. (1970, p. 144)

Specifically, she focuses on the following areas:

> (1) developing the capacity of attending to and identifying aspects of one's experience; (2) locating sensation and movement impulses and any other body feelings; (3) discovering the motions and dynamic movements of tensions as patterns that arise from the inner impulses; (4) . . . exploring the range of body functioning and expression as it emerges in the therapy, quality of efforts, tension-relaxation, blocking, and the particular function it serves in each case. . . . (1979, p. 144)

Janet Adler

Adler is another dance therapist who carries on the work of Mary Whitehouse. Originally well known for her work with autistic children, Adler today specializes in working with adults using "authentic movement." One of her particular interests is the role of the therapist as "witness" (the empathic observer role) in the therapeutic relationship. This concept, brought forward from her training with Whitehouse, has in recent years been a major area of study for Adler.

The witness, Adler (1985) explains, initially

> "carries a larger responsibility for consciousness as she sits to the side of the movement space [and watches]. She is not 'looking at' the person moving. She is witnessing, listening, bringing a specific quality of attention or presence to the experience. . . ." (p. 2)

As in the work of Whitehouse, Adler asks her people to move with their eyes closed. This she believes helps the individual to expand and deepen his/her awareness of unconscious and superconscious experiences. Most important in Adler's work is her emphasis on the relationship between the mover (patient/client) and the witness (or therapist). While the therapist/witness role can be generalized into the category of empathic observer role, it should not be confused with a passive experience. The relationship is an extremely active and interactive one, although the interaction may not be immediately apparent. In short, through the verbal and nonverbal interactions of the witness and mover, Adler believes that both can reach new heights of self observation, awareness, and insight. Ultimately, Adler believes that the awareness achieved has the potential to be transpersonal, that is, to go beyond the personal conscious and toward a universal unconscious (Adler, 1985).

While Adler discusses the transpersonal aspects of the witness-mover relationship, she is also cognizant of the similarities of the witness/mover relationship with that of the analyst/analysand relationship and notes the importance of understanding the transference and counter-transference phenomena which occur.

Expansion of the Mary Whitehouse Approach: Jungian Aspects

As mentioned earlier, Whitehouse incorporated into her work certain Jungian concepts which were passed on to and later expanded upon by some of her students. This section reviews the writings of some of the Whitehouse disciples who have further clarified this connection between Jungian thought and the use of body movement in therapy.

Joan Chodorow

Chodorow, formerly known as Smallwood, is a leading dance therapist and a Jungian analyst who practices on the west coast. Her dance therapy training was with Whitehouse and Schoop. She discusses her use of a Jungian approach to dance therapy in her article "Dance Therapy and the Transcendent Function" (1978). The "transcendent function," a Jungian concept, is an "innate, dynamic process that serves to unite opposite positions within the psyche," thus facilitating "a transition from one attitude to another" (1978, p. 16). Chodorow quotes Jung who described it as "a movement out of the suspension between two opposites, a living birth that leads to a new level of being, a new situation" (1978, p. 16).

In an earlier paper "Philosophy and Methods of Individual Work" (1974), Chodorow differentiates two approaches to dance therapy, one moving toward the conscious and the other toward the unconscious. The former, Chodorow believes, is usually more appropriate for the disturbed/psychotic patient, who needs a sense of conscious, everyday reality and movement experiences that strengthen ego boundaries. This approach, Chodorow states, may include:

> . . . use of structured rhythms, . . . clearly organized spatial patterns, [and] intentional use of weight [which] will help the person develop a more realistic body image and strengthen his or her conscious viewpoint. (1978, p. 17)

The second approach, which uses movement "as a means of opening to the unconscious" (1978, p. 17), is usually more appropriate for the fair-to-well functioning individual whose ego is more intact.

This delineation of therapeutic approaches corresponds to Whitehouse's differentiation between "I move" and "I am moved," as well as Dosamantes-Alperson's differentiation between the active and receptive modes of perception and behavior. Chodorow's purpose in proposing the two approaches is to gain clarity and better theoretical understanding of varying needs in different personalities. It is important to remember, however, that "in reality, there is often a constant interchange, an ebb and flow back and forth between the two" (Smallwood, 1974, p. 26).

Chodorow works primarily with "relatively stable individuals who possess a . . . strong ego viewpoint" (1978, p. 18). The focus of her work is the use of movement to give form to the imagination. Her therapeutic approach to exploring the unconscious and integrating it into consciousness is based on Jung's method of "active imagination" (a process which was discussed by Whitehouse).

In a 1986 interview, conducted by dance therapist and clinical psychologist Nancy Zenoff for the American Journal of Dance Therapy, Chodorow made many illuminating statements about her studies with Mary Whitehouse and Trudi Schoop and also about her clinical work. The following excerpts from this interview center around Chodrow's clarification and expansion of the Whitehouse work.

> NZ: Would you talk about how you use movement in analysis?
> JC: Movement is not essential for everyone, but it is essential for some. And it's helpful

for most people. Yet there are people I work with who rarely feel the need to leave their chairs. They're able to enter the imaginal world without getting up to move. I'm comfortable with that because that's their way. I think what's more important to me nowadays then whether someone moves or not, is whether we're able to open to the imagination or not. There are many ways of opening to the imagination, and each person has to find his or her own best way.

NZ: You said for some it's essential. How do you or they know that it's essential? What are your clues?

JC: In my experience, people generally know when they want to move. They know that in order to go into the world of the unconscious, they've got to ground it in the movement of their own body. Some people are able to just imagine by leaps and bounds. You don't know how they get from here to there. For myself, I'm not quite connected when I imagine in that way. That kind of fantasy feels disembodied. But when I move my body through the images, then I've truly entered into that world. The people who come to work with me want to do analysis, and most of them want movement to be part of it. So we do analysis. That means we talk about dreams, fantasies, life experiences, what's going on between us. We sit in chairs, or we sit on the floor. We do sandplay—use art materials.

Whenever there's a feeling of wanting to move, every person seems to approach it differently. There are some people who'll come and talk for fifteen minutes and then move for twenty, thirty minutes and then talk a little bit toward the end. Others will come in, and before anything is said, they'll close their eyes and begin to move. They simply go into that world and see what comes. After they're through, they'll bring it to an end, make a transition, and we may or may not talk about the movement that just happened. They're just as likely to be quiet for a while and then say, "Where's the clay?" and then form an image. Then we might sit down and talk about dreams. People often remember their dreams or early childhood experiences while they're moving. Or we might talk about how it felt between us while they moved, how they were aware of my watching the movement or what it stirred up in me as I watched the movement.

It's different for every person. Some people just move from what their own bodies want to do. Other people will see a specific image, sometimes like a guide person who appears in their imagination. The inner guide moves, and the mover mirrors or follows or interacts with the imagined figure. For some it's primarily a rite of entry into the analytic hour, where you get into your body and you separate from the everyday world. Movement and attending to the body experience can simply be a way of opening to the unconscious, and then we'll sit down and talk about dreams or something else. There's no particular form.

Whether we're talking or moving or engaging the symbolic process some other way, there's a kind of awareness that goes on. For me, whatever comes up from the unconscious usually has four aspects: one aspect is how is it happening here between us; another aspect is how is it happening in the person's life right now; the third aspect is what are the earliest memories from childhood of that same kind of experience; the fourth aspect brings in universal or mythic images.

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In one of his letters, Jung described active imagination as his analytical method of psychotherapy. Active imagination clearly includes dance/movement as well as all of the other art experiences. But it also includes imagining around transference and countertransference issues and possibilities of what the symbolic meanings might be of complexes that erupt in everyday life. In its most basic sense, active imagination is opening to the unconscious and giving free reign to fantasy, while at the same time maintaining a conscious viewpoint.

NZ: In your writings you've talked about the presence of the witness, the analyst. What is that presence?

JC: It's holding a particular kind of tension, because you bring your total being and total attention to the relationship. This is true whether you're sitting in chairs or whether the person is moving. But the experience is often more powerful when the person is moving and you're not distracted by words. Movement goes so directly to the emotional life.

I feel it's important to bring who I am and not try to clear myself or make myself too centered. When I've put a high value on being centered or receptive, I've found that I tend to split from the parts of me that are not like that. To the degree that I foster any particular attitude, its opposite tends to get constellated in the unconscious. So I've learned to just let myself be how I am and contain it.

What we're talking about now has to do with deliberately opening to the unconscious, yet not identifying with it. In other words, opening to the imagination doesn't mean merging with the images and off you go. Opening to the imagination means being yourself, with all your strengths and weaknesses, and noticing what you're imagining.

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There are so many different levels of witnessing. You notice what the body is doing. You're curious, interested in what the body is doing. You're noticing that. But you're also noticing the emotional tone, and if there's an infantile quality to it, something of a parental caretaking, nurturing feeling may come up. Or if there's a family history in the mover of being neglected or being mistreated in some way, those kinds of indifferent or rejecting countertransference responses can also erupt.

Then there's the whole realm of what does this person's movement stir up in me from a larger cultural perspective? How has this attitude or movement sequence appeared in art, how has it appeared in literature or mythology? What paintings come to mind, what poetry or music comes to mind as I watch the person move? In what way does this express a universal human experience? So it ranges from questions about what is this body doing—to imagining all kinds of possibilities about the person's life history, particularly the early history, that tends to come up so often in movement. It's all there while you're watching, but most of it is like a dream world: you can't retrieve all of it. Some of it stays, but you don't remember everything. In a sense it has a ritual quality. It's as if we enter sacred space.

NZ: Is the sacred space that you're talking about related to what you've referred to in your writing as "participation mystique"?

JC: The "participation mystique" is a phrase that Jung used to describe what we might call merging. It's when we are able to drop our boundaries in the presence of another. Sacred space is kind of like the inside of the magic circle. It's like the therapeutic container. Dora Kalff described a "free and sheltered space."

There is a tension we have to hold as we witness movement. On one hand, we deliberately open ourselves to the possibility of merging, *participation mystique*. It's like what Mary spoke of when she described a quality of movement with the word "inevitable." The witness is so connected to what the mover is doing that you feel you know what's going to happen next.

In this interview Chodorow candidly shares with us how she experiences her work. She tells us what works for her and what doesn't. She describes her fluid use of different idioms. In the section on Avstreih that follows, more will be said about the therapist as witness.

Penny Lewis

Lewis (formerly Bernstein) a dance/movement theorist, author, and clinician as well as editor of several books in the field, studied originally with Chace and Bartenieff and in recent years has been strongly influenced by Jungian psychology and object relations theory. Although she has worked with other populations, her present work centers around the normal and neurotic adult population.

In her article "A Mythological Quest: Jungian Movement Therapy with the Psychosomatic Client" (Bernstein, 1980), Lewis describes her work with Celeste, a young woman in her mid-thirties. Lewis' methodology focused on the use of symbolism and metaphor. She advised Celeste to keep a journal of "her contacts with her personal and collective world as they manifested themselves through dreams, active imagination and [other forms of awareness]. . . ." (1980, p. 48). Insights gained through the integration of expressive movement, reflection, journal work, and verbalization were discussed on three levels: the symbolic, the subjective and the objective (relationships to others). Through this process Celeste learned to understand the meaning of her images "and their relation to her life and journey toward wholeness" (Lewis, p.c. 1987).

In her work with normal and neurotic adults, Lewis also uses a Gestalt therapy approach. Her choice of a Gestalt therapy approach or a Jungian approach depends on whether the client is more of a sensation or an intuitive perceiver" (Bernstein 1980, p. 46). With the former, Lewis generally believes, the Gestalt approach is more appropriate, while with the latter, the intuitive, introverted Jungian approach is more suitable. The underpinnings of all of Lewis' work is object relations theory. Her use of the Gestalt therapy approach will be discussed later in this text.

Discussion

Comparing East and West Coast Trends

Chapters 14 and 15 examined east and west coast trends in dance therapy which emerged during the 1960's and 1970's, and which grew out of the influences of the major pioneers. Some interesting trends and patterns emerge when comparing east coast with west coast influences.

Broadly speaking, many east coast influenced leaders stress alternately the psychic structures of id, ego, and superego, the roles these play in body movement, psychosexual stages of development, and other psychodynamic and psychoanalytic concepts, including self-psychology and object relations theories. In addition, tools for the description of movement behavior and diagnosis, specifically Laban Movement Analysis, have received greater attention on the east coast. On the other hand, many dance therapists influenced on the west coast discuss their work with a greater focus on the immediacy of the movement experience itself, that is, the bodily-felt experience, and the psychic material it evokes. These therapists tend to stress the concepts of being fully in the here and now, "attending" to the physical and mental self, and finding one's "authentic movement."

There is also a greater west coast emphasis on the exploration of the individual psyche, in contrast to the east coast interactional and community stress. This is not to imply, however, that all therapists trained by a west coast leader stress only the immediacy of the movement experience while all those trained by east coast leaders are psychoanalytical and/or interactional. Nor does it imply that one excludes the other, but rather that the general emphasis and style of discussion appears to be more experientially and individually focused when west coast influences are present and more analytically and/or interactionaly focused when east coast influences are present.

These differences in east coast and west coast trends can be traced back to the work of Marian Chace[1] and Mary Whitehouse. According to the Survey Results (see Unit III), most of the dance therapy leaders on the east coast were trained or influenced by Chace and the majority of west coast leaders were trained or influenced by Whitehouse. These two major pioneers differed not only in theory, but also in practice. Chace worked with hospitalized psychiatric patients primarily in groups, with a major emphasis on the therapeutic movement relationship (a Sullivanian interactional approach) and the group rhythmic relationship. Whitehouse specialized in the more healthy population, often dancers, seen in her dance studio, and stressed a transcendent aspect of dance that carries individuals into another realm of consciousness and unconsciousness. The clinical differences between these two most influential leaders were, to a large degree, influenced by the needs of their patients and the setting individuals were seen in, as well as their dance backgrounds and of course temperamental differences.

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[1] Chace however was not psychoanalytic. The psychoanalytic influences on the east coast have come largely from Espenak, Siegel, Bernstein, and Avstreih.

However, there were also many less obvious trends that were set in motion by the other major pioneers. For example, in contrast to Chace, east coast pioneers Evan and Espenak were working with the normal and neurotic population, while Schoop and Hawkins (in contrast to Whitehouse) were doing hospital work on the west coast. In addition, Evan and Espenak were influenced by Adlerian and psychoanalytic concepts and Hawkins by humanistic psychology. Schoop stressed community and society. She moved with her patients and always brought movement back to conscious control and "performance." Evan and Espenak explored the unconscious through improvisation in ways not totally dissimilar to Whitehouse. All three were influenced, either directly or indirectly, by Wigman's improvisational work. If we examine what John Martin (1972) said about Wigman's work, the similarities are clarified. He states:

> The . . . result . . . is the appearance of entirely authentic movements which are as closely allied to the emotional experience as an instinctive recoil is to an experience of fear. (p. 60)

While approaches certainly vary and theoretical differences clearly exist, it is also quite possible that the range of experiences the patient actually has in dance therapy sessions may overlap more often than our distinct theoretical and practical frameworks would lead us to believe. In other words, it is possible that some of the differences between east and west coast trends may be more semantic than experiential. A possible direction for the future might be to study the language of dance therapists on both coasts to see in what ways the meanings behind the words may be similar or different. Consistency in the vocabulary of dance therapy could be a potent tool for communication amongst dance therapists as well as with allied professionals. Complexity of language, on the other hand, could lead to intellectual conflicts which might blur the psychomotor experience.

It is also important to note that overlaps among all of the leading dance therapists discussed so far exist, for example, to bring subjective experiences forward through the body, to create a safe, permissive and non-judgmental environment in which patients can express themselves freely, and to establish a deep empathic rapport, summarized frequently in the colloquialism "starting where the patient is." In recent years, there have been signs that a new trend is emerging with a more conscious blending of east coast and west coast influences. Four leaders, educators, and authors who integrate east and west coast influences are Marcia Leventhal, Zoe Avstreih, Fran Levy, and Penny Lewis.

Marcia Leventhal

Marcia Leventhal (1980), Associate Professor and Director of New York University's Graduate Dance Therapy Program, is widely known for her work in dance therapy with the special child (see Chapter 18). Her extensive training in psychoanalytic psychotherapy, Gestalt therapy, and psychosynthesis is complemented by her dance therapy studies with Hawkins, Whitehouse, and Valerie Hunt (1970, 1972). Hunt, retired professor of Kinesiology and Movement Behavior at UCLA, was director of the Bio-Energy Field Lab in Malibu, California. Other influences on Leventhal include east coast pioneers Evan and Bartenieff. This unique combination of training and influence drew Leventhal toward dance therapy with the fair-to-well functioning adult population.

From her work with Hawkins and Whitehouse, her major mentors, Leventhal became committed to the study and exploration of the therapeutic benefits of rhythm, both as a structure inherent in movement and in conjunction with the movement interaction between patient and therapist. This, one of the major themes of her recent work, has also been the subject of her numerous lectures around the world. Leventhal believes that "dance therapists will ultimately make their contribution to the psychotherapies by offering methods for reaching . . . those clients stuck in a stage or level reminiscent of an earlier, less defined preverbal time." (1986). Based upon the dance therapist's unique observational skills and their involvement in basic "energy exchange," Leventhal describes how the dance therapist is able to meet the client through movement interactions, "on the developmental level most foreground for the individual at the time of interchange" (1986). This level is translated into what Leventhal calls "flow readiness."

> Using the perceived movement expression as the organizing base of the relationship, the therapist helps catalyze 'energy events' in the therapy which develop into movment experiences. These experiences have personal import for the client." (1986)

In 1976 Leventhal integrated her broad dance therapy training into a therapeutic structure which she calls "The 5-Part Session." These include the warm-up, release, theme, centering, and closure. The five areas move from highly structured to less structure and back to structure.

She describes these phases as follows:

Warm-up	*Transition* Becoming present, aware, ready for transition from verbal mode to non-verbal expressive mode
Release	Release of obsessive thoughts, residual tension, becoming ready and Receptive to ...
Theme	*Discovery,* felt level, unfolding, trends, (psychodynamic and movement)
Centering	Stillness, containment, re-focus, alignment, integration

Closure	Transitional, conclusion; back to here and now, return to verbal mode

Leventhal believes that these five phases provide the client with a feeling of organization, and hence safety—"offering . . . a natural sense of completion or wholeness" (1987, p. 33). She feels that they are akin to creating a "holding environment" (Leventhal, 1986) for the client. Building such a structure into the session allows the client greater freedom of expression. This structure also aids the therapist in clarifying emerging themes.

Interestingly, structures similar to this one are cited throughout the history of dance therapy. Many of the major leaders, through a combination of early training and individual experimentation, find formats similar to Leventhal's "5-Part Session" helpful.

Zoë Avstreih

Avstreih, mentioned in Chapter 13 (east coast trends) for her dance therapy work integrating psychoanalytic theory from a self-psychology perspective, has for several years been exploring the work of Whitehouse. She believes that there is a correspondence between the therapeutic stance of the psychotherapist working from a self-psychology framework with that of the "witness" as described originally by Whitehouse and elaborated on by Adler and Chodorow. Presently Avstreih directs the Whitehouse Center, a center for the study and practice of authentic movement in New York (formerly the Mary Starks Whitehouse Institute founded by Adler in Massachusetts).

Interestingly Avstreih began her dance therapy studies on the east coast at Hunter College where she studied the Chace technique with Schmais and White. She notes that Chace emphasized the role of the dance therapist as the non-judgemental observer ("witness") and in addition emphasized the benefits of the dyadic union and interaction between patient and therapist. Avstreih, however, differentiates the empathic responses utilized in the Chace technique from the pure non-directive experiencing role of the Whitehousian "witness/mover" relationship. She believes that the Chace dance therapist, while initially witnessing the "mover" (patient), then moves on utilizing the therapeutic movement interaction to help the mover organize and express themselves.

In response to this use of the therapeutic relationship, Avstreih states that "as soon as there is an intervention or interpretation of any kind (guidance is a form of interpretation) the role of the 'witness' is altered and the witness stance, is no longer in its pure form." (1987, p.c.)

The witness role is a totally experiential, non-intrusive, non-directive role. The "witness" simply experiences the mover (patient/client or student) and him/herself with no interest in altering the mover's state. The "witness", like the mover, is taught to attend to his/her own subjective and unconscious process and the insights obtained on both sides are, when indicated, shared (Adler, 1985 and Avstreih, 1987, p.c.). This differentiation brings Avstreih to an important question which she is brave enough to ask: Is the "witness/mover" relationship really therapy? Just asking this question is, in and of itself, a contribution. She is also intelligent and humble enough to admit to not knowing the answer yet but is sincere in her efforts to understand this powerful and puzzling dynamic.

Fran Levy

Levy, also influenced by both east and west coast trends, believes that we work with patients on a continuum from most to least directive and that each individual, over time, teaches us what they need and when. In viewing the therapeutic interaction on a continuum, and realizing that it is an oversimplification to say that all hospitalized patients need one way of working and all non-hospitalized patients a distinctly different way, we see the importance of blending and adopting aspects of both the major east and west coast trends.

The melding of influences among younger generations of dance therapists is inevitable. As noted in the Survey Results section, most of today's leaders have studied the work of at least two of the pioneers, and many of these leaders are now teaching throughout the United States and world wide.

Finally, some dance therapists now blending east and west coast influences are also integrating aspects of the action-oriented psychotherapies into their practice. Lewis integrates drama and Gestalt therapy techniques and Levy integrates a psychodramatic format and other creative arts. Both are participating in another contemporary dance therapy trend, that is, the integration of other action-oriented psychotherapies into dance therapy theory and practice. Levy's work will be discussed in the following chapter.

Penny Lewis

The Gestalt therapy approach, like psychodrama and dance therapy, stresses the importance of individuals being actively involved in an experience instead of merely talking about it. Growth in therapy, according to Lewis, is more likely to come about when the individual can participate in and achieve "full identification with the process" (Bernstein 1979, p. 111).

> This process of allowing an individual's total being to become immersed in the expression of the unconscious—not just talking about it, but fully experiencing the symbols—affords him direct contact with parts of his being which he may have previously disowned or of which he has been unaware. (1979, p. 114)

In a supportive environment, the individual can allow the symbolic expression to become real, and allow him/herself to express it without fear of consequence.

Gestalt therapy does not categorize, label, or "diagnose" people; rather, it explores patterns of behavior. The focus is on the individual's behavior and attitudes in the here and now. Lewis outlines some exercises adapted from Gestalt therapy that can help the individual become aware of his/her "habitual body patterning" (Bernstein, 1979, p. 118). These include the following:

1. *Sense awareness body journey*—the individual focuses attention on breathing, body parts and internal stimuli, and becomes aware of blocks and areas of tension.
2. *The body talks*—the individual is asked to "take a trip inside the body and to speak from each part that wants to say something" (1979, p. 119)
3. *Intensification and personification*—exaggeration of a gesture, movement, or breathing pattern, vocalization of tension in different parts of the body, and personifying the symbolic process (i.e., acting out dreams; use of myths).

The therapist's role is that of a guide and facilitator, assisting the patient as he/she journeys inwardly toward increased self-awareness. Empathy and sensitivity are essential (Bernstein, 1979).

Interestingly, Gestalt therapy, originated by Frederick Perls, developed in popularity in the 1960's on the west coast. In Lewis' discussion of its relevance to dance therapy, one can hear familiar west coast themes of sensing, attending and intensified individual self-expression.

Aside from this article by Lewis, little has been written on the integration of Gestalt therapy and dance therapy. Important work is being done, however, by leaders such as Linni Silberman (1985), who, like Lewis, has been active in synthesizing many contemporary dance therapy trends.

In addition to Gestalt therapy, other action-oriented psychotherapies are also being incorporated into the work of dance therapists. The following chapter dicusses Levy's integration of psychodrama and dance therapy with the visual arts.

16

Psychodramatic Movement Therapy

THE INTEGRATION OF DRAWING AND DRAMA INTO DANCE-MOVEMENT THERAPY

The incorporation of dramatic technique into the dance therapy process can be traced back to several of the early dance therapy pioneers. The introduction of dramatic enactment by Boas and Evan, dance-drama by Rosen, characterizations by Schoop, and role-playing and patient productions by Chace and Genther all demonstrate the early integration of dance and drama that was noted in Unit I.

In more recent years, Fran Levy has formalized this merger between dance therapy and psychodrama into a creative action-oriented approach to group and individual psychotherapy, which she calls psychodramatic movement therapy. This approach, which blends east and west coast dance therapy trends, includes not only drama and dance, alone and in combination, but also drawing and visualization when indicated.

Levy's methods reflect an eclectic background including training in the following areas: clinical social work, psychoanalytic/psychodynamic concepts with clinical psychologist Sidney Levy; psychodrama and group psychotherapy with clinical psychologist Robert W. Siroka; and individual psychotherapy with clinical psychologist Ellen Siroka. From a more dance and dance therapy perspective, Levy integrates the teachings of Blanche Evan, Melissa Laughman, Albert Pesso (his early work), Martha Graham (modern dance technique) and Fara Krasnapolsky (creative expressive dance). Levy's training with Laughman was unique in that Laughman integrated aspects of the Wigmanian improvisational work of Whitehouse with the therapeutic movement relationship of Chace.

Levy works in private practice as a primary psychotherapist working both individually and in groups. She complements her psychotherapy work with creative techniques borrowed from dance therapy and the other creative arts therapies.

Levels of Abstraction and Internalized Roles

At the heart of Levy's approach is the concept of reaching the individual through the medium which the individual finds most expressive and at his or her level of abstraction. Those who are unable to deal with a conflict directly might express it abstractly. The more anxiety that is present, the further away the individual will go from the original feeling. Starting where they are—at their own level of abstraction—the therapist can help them express unresolved or conflicting emotions and begin a process of uncovering layers of meaning, reaching ultimately to the original source of conflict.

Typically, dance/movement exploration and/or visual art experience will provoke conflicting emotions and loosen the tied-up energy connected to the conflict. This leads the patients to bring forth themes or images which can be structured by the therapist verbally and nonverbally into directed and focused dramatic dance-movement action. For example, a simple movement exploration of the color red (the client's color choice) could allow the individual to get in touch with movements of anger or frustration, which could lead to images of specific people in his/her life for whom there are unresolved or conflicting emotions. In this way, the client moves from an abstraction (i.e., unidentified feelings of anger, expressed symbolically through the idiom of color) to content (images of specific people towards whom hostility is directed). The conflict can then be explored more deeply through psychodramatic movement structures. These structures would involve the playing out of feelings in relationship to the person toward whom hostility is expressed.

Levy views drama as a medium ideally suited for dealing with conflict, for inherent in it is a division of roles, or characters, and an interaction among them. In the case of inner conflict, Levy believes, unresolved or conflicting emotions are often projected onto an entire cast of internalized characters, or roles. Some of these are "significant others," (Moreno, 1975) that is, influential people in the person's life who have been internalized. Their influence is sometimes highly emotional and conflictual, as in the case of an internalized "bad mother." Others are different parts of the individual, representing various life roles which have not been given adequate expression and completion. These characters, including some from every stage of development, assert themselves from time to time, expressing their own age-appropriate feelings. The diverse needs and demands of these internalized roles reflect unresolved or conflicting emotions that need to be externalized, explored and understood. It is the conflict between these roles that brings an individual into treatment. If there were no conflict, if the opposing roles which live in us all were balanced in such a way as to not create tension (internal conflict) then treatment would not usually be sought.

Psychodramatic techniques, including role-playing and role- reversal, provide a vehicle through which the individual can act out his/her inner dramas in movement and verbally. The psychodrama connects and transforms the energy tied up in thoughts and feelings and allows it to be expressed in action, thus bridging the gap between the mind (thoughts and feelings) and the body (movement). Expressing the unresolved or conflicting emotions tied to the various roles releases them from the body, reducing tension. This frees the individual to deal with the emotions in more useful and appropriate ways and to function in general on higher and more constructive levels.

Psychodramatic Movement Therapy: Methodology

The therapeutic sequence of psychodramatic movement therapy sets the stage for the patient to acknowledge emotional conflict, feel the conflict, become aware of associative imagery, participate in dramatic structures (role-playing), experience catharsis, and gain insight.

The following illustrates how a psychodramatic movement therapy sequence might develop. After a thorough movement warm-up, the therapist could encourage the exploration of movements that express opposing feelings or intentions, such as push-pull, gather-scatter, hard-soft, or direct-indirect. The therapist would then help the client choose the set of opposing movements he/she would like to explore in depth. This could be done by trying several possibilities with the client and then focusing on the one the client responds to the most, encouraging him/her to broaden, expand, and amplify the contrasting movements.

This can lead to role-playing, what Moreno (1975), the founder of psychodrama, described as "the personification of other forms of existence through the medium of play" (pp. 140–141). During this phase, the therapist encourages spontaneous role change, or role-reversal, back and forth between the two contrasting movement themes. For example, the client might first become the role of "the push" movement and then that of "the pull" movement, continuing back and forth until he/she comes to a feeling of completion. In group work, role-reversal usually involves two (or more) people in dramatic dialogue with each other, moving back and forth between roles in a dramatic exploration of both (or many) sides of the dialogue. Through role-playing the client is permitted to express his/her emotions in new roles and in this way can clarify the emotions associated with conflict.

While the client is exploring his/her feelings through role-playing and role-reversal, free association in movement would be encouraged. To facilitate this, the therapist might ask questions such as, How does this movement feel? or, Do you want to add sound or words to your movement? The client would be asked whether he/she is having any associations to the movements (thoughts, feelings or images), and if so, whether the associations can be described in terms of a color, movement, shape, rhythm, texture, and so on, which could be "danced out". Such questions and suggestions could help the client to focus and organize the underlying emotional themes. This, in turn, promotes catharsis, clarification and insight.

Another technique could be to ask the client if "the pull" has something to say to "the push" or if the client would like to give names to "the push" and "the pull." The client might be asked to create a dramatic story using these roles in movement. During this process, individuals frequently become aware that the movements they have chosen represent significant people in their lives or other parts of themselves. For example, one of Levy's clients became aware that "the push" movement was her father who always "pushed her away," while "the pull" movement was her mother who always "pulled her here and there." Another client became aware that "the gather" was the mother she never had and "the scatter" was her actual mother. This individual longed to have a mother who would "gather her up" in her arms and hold her. The scatter movement facilitated this client's expression of anger at her actual disorganized and scattered mother.

From the individual's verbal and nonverbal responses, the therapist can assess the level of abstraction and/or content on which the client is ready to focus his/her emotions, as well as the dramatic structures through which he/she might best express those emotions. The therapist would then help the client to set up the appropriate structures and scenes within which the psychodramatic movement action can take place.

The psychodramatic action complements the dance therapy process by clarifying, broadening, and deepening the movement or bodily felt experience. It facilitates the externalization of mental and emotional structures and gives emotional content to abstractions and mental images. It brings structure to disorder and puts irrational, disconnected expressions into a rational, dramatic, and explicable order. This provides a system of feedback for perceptions and reflection as well as a richer understanding of inner conflicts, and often leads to further movement exploration toward a more pure form of emotional expression via dance.

Elly. The following case of Elly, a tall slender financial analyst in her late forties further illustrates the clinical application of psychodramatic movement therapy. Elly, a fragile woman with suicidal tendencies, began one of her sessions with the statement, "I'm crazy today, I've been crazy all day." When asked what "crazy" meant she replied, "Well, I just feel torn apart." Levy then asked her to describe this torn apart feeling more specifically, for example, identifying how many parts of herself there were and whether they had any particular shape, form, color, or texture. She replied, "I feel torn into four parts," but could not describe them verbally.

Levy suggested that Elly become these four parts in movement, giving each part its own place in the room. As she moved to the first place, her posture changed and she began to gesture angrily, as if scolding someone. Asked whether this part (role) had a name, she replied, "My mother." After exploring this figure in movement with some verbalization, she moved to the second place. Again, her posture changed and she took on sexually provocative and aggressive attitudes. This part she recognized as representing her step-father. In the third place, Elly again began to gesture angrily as if ridiculing and teasing someone. After doing the movements, she realized she was portraying her sister. As she moved into the fourth part, her posture immediately collapsed and she assumed a withdrawn appearance, acknowledging this to be herself. It was as if her body had given up under the internalized pressure of her family's anger and provocation.

Upon seeing her withdraw, Levy encouraged her to allow a movement dialogue to develop between herself and each member of her family, role-reversing with each member as she desired. Through enacting the role-reversed positions of mother, father, and sister, she was able to manifest a great deal of her own anger. (Frequently, a client is more able to express certain emotions through role playing significant others than in his or her own role.) The stress here was on expressing the movements as well as the words of the significant others, and in this way Elly's feelings were organized both verbally and physically through the acting-out process.

As Elly's drama continued to unfold, various group members spontaneously took on the role-reversed positions of mother, step-father, and sister according to what Moreno called sociometric choice. Sociometry, applied to the group therapy process and psychodramatic technique, refers to the measure of relationships and networks within the group, as well as to each individual's own network of significant others or relationships outside of the group (Siroka, 1980, p.c.). The group members who chose to participate in Elly's drama were drawn on an emotional level to play the role(s) they identified with. In this way, members of the psychodramatic audience (i.e., the group) became spontaneously involved in the drama, rather than being assigned roles, hence the role-playing acted as a springboard not only for the protagonist's (Elly's) feelings but also for the feelings of other group members. The sociometry of the group was a major vehicle through which Moreno structured psychodramas. Generally, it is the psychodramatist's use of relationships, transferences and identifications, that is, sociometry, which make for a successful, emotionally meaningful group session.

This session provided a major breakthrough in Elly's therapy. Through the release of her own aggressive feelings in the role-reversed positions (i.e., mother, step-father and sister), in combination with the group's participation in these roles, Elly became more able, within the dramatic movement structures of role-playing, to communicate with and respond to each family member. This helped her bring to conscious awareness the content behind her confused, angry, and upset feelings. What had once been experienced as amorphous, and therefore menacing, was now organized dramatically into shape, imagery, rhythm, movement and words. By externalizing the emotions which had been tearing her apart, Elly gained insight into her own intrapsychic complexity. This marked the beginning of control over her own feelings and actions, and as a result her suicidal thoughts decreased significantly and gradually her actual family relationships improved.

Psychodramatic Movement Therapy Facilitated by the Graphic Arts[1]

Psychodramatic movement therapy begins where the client is, working with conflicting or unresolved emotions at the level most comfortable for the client. As stated earlier, Levy recognizes that individuals vary not only in the level at which they are ready to deal with conflict, but also in the medium through which they can best express that conflict, at whatever level of abstraction or content. Psychodramatic movement therapy can incorporate several different expressive media which, used creatively and flexibly on many levels, enable the therapist to help individuals in their own unique ways to approach the unapproachable. These expressive media include dance/movement, drama and verbalization, as already discussed, as well as the graphic arts when indicated.[2]

The graphic arts (drawing, painting, coloring, etc.), like psychodrama, is a natural medium for the expression of inner conflict. Art work requires that the individual make choices, and these choices are often symbolic projections of conflicting or unresolved emotions. Even if asked to draw something specific, the client still must choose colors, textures, shapes, and symbols. The rhythmic action of the individual's hand movements on the page is also a choice, for example, soft curved lines, jerky quick motions, dark heavy lines, or staccato movements as in making dots. With each choice the individual makes, he/she externalizes an aspect of self.

For those individuals who are comfortable with this medium, the graphic arts can facilitate the psychodramatic movement experience in a variety of ways. First, it is a projective technique which provokes psychological material and manifests it in a visual form. This enables the individual to step back from it and reflect on it. Second, the material can be expressed artistically at various levels of abstraction or content, depending on the individual's readiness and preferences. A drawing, for example, can be vague and symbolic or representational and specific, or any level in between, and the individual can interpret it as deeply as he/she is ready to. Third, the interpretation of a drawing can take several different forms, verbal and/or nonverbal. Thus, the graphic arts experience can serve as a springboard to further exploration through other expressive media—dance/movement, psychodrama, verbalization, dramatic dance movement.

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[1] Levy's training with Jean Peterson, a registered art therapist, clinical social worker, and psychodramatist were most helpful to her in the development of her use of art therapeutically. She was also deeply influenced by the literary contributions of leading art therapists including Art Robbins (1980), Edith Kramer (1971), and Elinor Ulman (1975).

[2] The creative psychodramatic work of Robert W. Siroka, Ph.D., Co-Director of the Institute for Sociotherapy, has been extremely influential in the development of Levy's creative techniques.

Chris. The case of Chris, a small blonde sexually repressed woman in her late thirties, can illustrate how art can be incorporated into the psychodramatic movement therapy process in an individual session. Chris had previously been hospitalized for a psychotic episode in which she had taken off her clothes in a subway car. She had since then disguised her sexual feelings and the guilt these feelings provoked, and projected them onto the image of a cloud which she visualized sitting on her head. She described the cloud as heavy, stiff, and constricting, with many layers. This symptom, known as "misplaced concreteness," is the schizophrenic's defense against feelings (Arieti, 1974).[3]

Levy suggested that Chris role-play by stepping away from the self with the cloud and responding to the cloud alone. She did this by expressing anger at it and a desire to remove it. When asked what she could do to remove it, she attempted to take it off using pantomime movements. This of course didn't work. Levy then asked if she could choose one part of the cloud and interpret its meaning in movement. In response, she did movements which released sexual energy through sensual arm motions. The rest of her body was essentially still except for a very slight and occasional hip motion. When she finished and was asked how the cloud felt, she replied, "It feels lighter and more flexible." Now that Chris was tapping into her repressed sexual energy through safe disguised movements, she felt relieved of some physical pressure; hence, the cloud felt lighter and more flexible.

Levy then suggested that Chris draw her feelings. Knowing that Chris enjoyed drawing, Levy felt that artistic expression at this point might pave the way for deeper exploration through dance/movement (also a medium Chris was comfortable with). Chris proceeded to draw pictures of plants which held sexual symbolism and allowed for further release of pent-up sexual drives.

In the dance improvisation that followed, and resulting from libidinal discharge, Chris had a sudden image of her mother scolding her. This image made her aware that her mother was the source of her conflict, anger, and guilt. Through role-playing and role-reversal, Chris entered into a dramatic movement dialogue with her mother introject. She verbally and nonverbally challenged her mother's right to control her every movement and emotion, by psychodramatically expressing her anger at her mother and showing off her new-found sexuality.

In the sessions that followed, Chris continued her dance/movement, artistic, and dramatic explorations of her sexuality and anger. Intense guilt feelings continued to be expressed and worked on. After a few months, the symbolic manifestation of her repressed emotions, the cloud, almost totally disappeared. While her feelings still created deep conflicts, she now had creative avenues of expression to help her cope with intense emotions.

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[3] Both psychodrama and dance/movement therapy begin where the client is and work with whatever is most real to the client. For some individuals, talking in metaphors, using animals, colors, or plants is as real as talking about emotions. Some clients experience their feelings as concrete realities. For example, several of my clients visualize something large and heavy sitting on their head or an animal crawling on their body (Arieti, 1974). For such clients, feelings are transformed and translated into concrete images. In these instances, no longer does one feel like a monkey is on one's back; it now actually is on one's back. No longer do thoughts and feelings feel like they weigh heavily on one's mind; they now sit there in the form of a weighty concrete headpiece or a band around one's head.

Art, like drama, can act as an intermediary step connecting the intellect (words) with the body (movement). The inherent limitations of artistic materials (paper, crayons, etc.) place a natural boundary around the psychomotor aspect of the experience, restricting the expression largely to finger, arm, shoulder and upper body movement on a defined space—the paper. These limitations can be helpful to some individuals, for whom complete body action (i.e., dance/movement) may initially be too threatening. Limiting their movement expression to upper body action allows these individuals a measure of muscular release which is safe and confined. The artwork safely frames the individual's experience (Robbins, 1980). This can later lead to more complete physical expression through dance/movement if indicated, or if contra-indicated, can simply enhance and deepen verbal expression.

Brenda. The case of Brenda, a 23-year-old research assistant, tall and robust, illustrates this. Brenda came for dance/movement therapy as a result of her dissatisfaction with traditional verbal therapy. She had discovered that she was using words as a barrier against feelings and hoped that using movement to express her emotions would help her. However, it soon became clear that movement was too exposing and frightening for her. As a result of a particularly rigid and repressive family background, she had internalized parental taboos that prevented her from expressing herself physically. The inhibition of her angry feelings had become generalized and attached to motor movements as well. Initially, even very small bodily motions would throw her into panic.

When Levy suggested that she draw her feelings, her previously withdrawn body became animated and expressive, her rigid muscular defenses gradually relaxed. Her movement repertoire expanded as she depicted various rhythms, textures, shapes, and forms within the safe confines of the drawing board. Larger pieces of paper were introduced as she became ready to handle more space. After draining off through drawing the excess rage that threatened the integrity of her ego, she was able to experiment with small movements, basically head rolls and leg and arm swings.

Brenda, however, was discouraged by her continuing inability to "dance", feeling there was something deeply wrong with her. She urged the therapist to push and criticize her, as her parents had always done. Levy instead reassured her that she was doing just fine and refused to take on the critical controlling role of Brenda's parents. Brenda responded to this kindness with tears. At that moment, she experienced a deep sense of acceptance from the therapist. She had to know that she was all right just the way she was, and this acceptance was more important than succeeding in the designated medium (i.e., dance/movement). Interestingly, Brenda came from a very actively conservative political family and always felt that her family put their beliefs before hers in importance. This feeling was now being transferred to the therapist. Because Levy (as "a dance therapist") was now being seen as the parental figure and was perceived by Brenda as a dancer, Brenda was sure that dancing in the sessions was more important than just being true to herself. This negative transference had to be interpreted and worked through.

Another interesting aspect of this case was that the patient described herself as having been an extremely physical child, "a tom-boy." She recalled that her so-called "boyish behavior" (which to Brenda meant having fun) was discouraged and ridiculed when she entered puberty. She also recalled her family turning away from her at this time as though something was wrong with her. As a consequence, an introject of parental taboos developed which prevented her from engaging more freely in spontaneous movement for fear that what she perceived to be her "secret masculine" side would slip out. Regarding puberty she stated, "I couldn't play rough anymore. It wasn't ladylike. I felt disgusting, like I was really bad. . . , a misfit. I feel a lot of shame" (tears and anger followed).

Frequently, in discussion or in exploration of movement, Brenda would recall her mother's reactions to her behavior during puberty. She also remembered both parents trying to inhibit her artwork during early childhood, an activity which had also been very meaningful to her. However, their ridicule in the artistic area, though destructive, did not leave her severely impaired, as it did in the area of motor expression. Before Brenda even began to move in the sessions, she had to spend a lot of time liberating her ability to draw, and the aggressive, sexual, and tender feelings therein. This brought forth powerful and symbolic memories, associations and emotions which were later developed through dramatic body movement, role playing and pretend games as in baseball, tag, and leap frog. Through these games Brenda could act out competitive and aggressive feelings which she had been labeling as her masculine side, without fear and guilt. In addition, by acting out the various roles in these games, she created her own psychodramatic stage and became all of the "players". As she expressed the anger, aggression, contempt, ridicule, sexuality, and affection that the players felt toward each other, she creatively and symbolically played out the interaction in her family and her own emotions.

In Brenda's case, destructive parental influence had left her severely impaired in the area of psychomotor expression, and verbal therapy had proved unsatisfactory as a vehicle for emotional exploration. The art work accompanied by dramatic-movement served as an excellent intermediary experience between pure dance, which was too threatening, and pure verbalization, which was devoid of feeling. Because of the depth of the emotional pain associated with family taboos and feelings of rejection, much of the work with Brenda was done through symbolic acting-out.

For other individuals, total body action may not in itself be too threatening but can at times provoke emotions that are too powerful for the person to handle. In such cases, the psychomotor limitations of the graphic arts experience can serve as a safety valve, diluting the intensity of highly charged thoughts and feelings. This enables some degree of emotional expression without overwhelming the fragile ego defenses of some clients, and can pave the way for more intense emotional release through dance/movement.

Karen. Such was the case in Levy's group work with Karen, a young small red headed actress with intense feelings of rage that threatened at times to overwhelm her. In one group session anger at male figures was the dominant theme. While the other group members were expressing anger in movement, Karen became upset, feeling nauseous, dizzy, and anxious. Levy suggested that she sit down, take a piece of paper and choose colors to draw with which best expressed her feelings. Her body stiffened as she began drawing, but gradually she allowed the emotions to display themselves in dark red lines, filling the entire page. During this process her nausea disappeared, her face became more relaxed, and her drawing movements more directed and purposeful.

Levy then asked her if she could write her feelings on the page (Schloss, 1976). Karen took a new sheet and in large letters wrote angry words about her husband. When she felt more in control of her anger she stood up and spontaneously joined the group.

She began to move with tremendous strength, dancing to the strong beat of primitive drum music. The rhythmic beat of the music and the boundaries of the drawing page both served to structure, limit, and define the expression of her potentially explosive feelings. These safety valves kept her in the present, related to the group and the therapist, and reduced the risk of overwhelming her ego. Karen emerged from the rhythmic dance expression feeling clear, strong, and invigorated.

Having discharged and thus diluted the original emotion, Karen felt ready to deal with some of the underlying issues fueling her rage. Since the group members were familiar with Karen's issues concerning her husband, and since most were attuned to Karen's feelings, they were able to spontaneously interact with her through dramatic dance-movement (in the role-reversed position, i.e., Karen's husband). They began expressing physically and verbally her husband's abusive, aggressive behavior. In so doing, they provided visual and psychomotor stimuli that Karen could react to and interact with, enabling her to further express the anger at her husband she had begun exploring through her drawing. This helped her to move along in her drama.

At one point, when Karen was having trouble standing up to her "husband" (the group), one of the group members (Pia) most attuned to Karen moved close to her and supported her emotionally by joining her in synchronous movements. The movement reflected a deep empathy with Karen's pain, frustration, and rage. In coming to Karen's support, Pia became what is called the psychodramatic double or auxiliary ego. "The auxiliary ego becomes the link through which the patient may try to reach out into the real world" (Z. Moreno, 1966, p.8). The auxiliary ego (double), interestingly, uses dance therapy techniques of kinesthetic empathy to become, in a sense, one with the protagonist.[4] A good double, one who is in deep empathic rapport with the protagonist, can be helpful in ways similar to the styles of interaction discussed in the Chacian therapeutic movement relationship (Keiser, 1976). With Pia's support as the psychodramatic double, Karen was able to continue her expressive movements.

This was followed by a division in the group. Those who identified with the aggressor stayed in the role-reversed position of "husband" and those who identified with the rage of being aggressed against joined Karen and Pia. At this point the group's expressions integrated a chorus of verbalizations and expressive dance-movements.

During this session, sociometric choices were spontaneously made many times. The initial sociometric choice was made when Karen naturally emerged as the protagonist in the group. She appeared to be containing an overload of feelings with which the group readily identified and responded. When Pia spontaneously emerged as a double for Karen, she was making a sociometric choice. Her identification and empathy drove her to move physically toward Karen and join her in expressive movement. When the group split another sociometric choice took place. Those who identified with the aggressor remained in the role of husband, while those who felt victimized moved toward Karen and helped her to express feelings of being victimized or aggressed against. These choices, made by group members individually, were all influenced by the sociometric networks within the group and each individual's own sociometry (network of relationships outside the group).

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[4] The concept of doubling and other psychodramatic techniques and concepts extend beyond these brief definitions. More information on psychodramatic technique can be found in the writings of Lewis Yablonsky, Howard Blattner, and publications from Beacon House Press in New York.

This group illustrates the spontaneous progression of a psychodramatic movement therapy session. This particular group had been together for many years. The members knew each other very well and were friends outside of the group as well. The techniques of role-playing, role-reversal, doubling, sharing, and sociometric choice had all become a natural part of this group's interaction style. This, of course, helped the process to unfold organically with little direction from the therapist.

Generally speaking, Levy rarely assumes "directorship" in the formal psychodramatic sense, preferring to relinquish leadership as much as possible to the individual protagonist whose drama is being explored and to the group (or psychodramatic audience). In this respect, Levy's work differs from traditional psychodrama. In traditional psychodrama, for example, the director usually decides on the basis of client cues when a client should reverse roles. Levy, in psychodramatic movement therapy, encourages clients to make these decisions independently based on internal reactions. This gives the client a feeling of control over the drama and helps them to trust their own psychomotor responses.

The psychodramatic director also traditionally plays a large role in setting the scenes and continually guiding the dramatic action with clarifying questions such as: How old are you now?, In which room are you sitting?, What do you see in the room?, Is anyone with you?, Are there any smells in the room?, and so forth. In this way the director focuses the protagonist, bringing memories and feelings from the past into the present. Levy also uses these techniques, but primarily to help the individual begin his/her movement exploration. Once the scene is set and the dramatic-movement action has begun, the individual is often encouraged to direct his/her drama through free association on a psychomotor level using dance/movement. At this time, the individual may decide to consciously and actively reverse roles or may incorporate and express all of his/her feelings without clear role changes but through an integrated dance improvisation. This aspect of psychodramatic movement therapy shares some of the same elements as the active imagination process of Whitehouse, the improvisational enactments of Evan, and the questioning patterns described earlier in the sections on Chace, Evan, and Whitehouse.

Group psychodramatic movement therapy also differs from traditional psychodrama, not only in terms of the director's role as discussed above, but also in terms of the director's role as discussed above, but also in terms of participation by the audience (i.e., other members of the group). What Moreno called the audience (those who surround the stage and observe the protagonist's drama) Levy views as physically as well as mentally engaged in the action, a form of Greek Chorus. This chorus of empathic observers might express in dance/movement the feelings they experience while observing the protagonist. The protagonist at any time can interact with the "moving audience" by means of the various therapeutic styles used in the Chace technique, that is, mirroring, interaction movements, and so on. This results in the spontaneous occurrence of multiple "mini dramas" (R.W. Siroka, 1976, p.c.), which allow the individual to explore thoughts and feelings individually, in pairs and/or in small groups. These differences are best illustrated in the case of Karen.

Levy's goal is to remove the psychodramatic movement therapy experience from the formality of the stage/audience/director format into a fluid dramatic interaction, directed as much by the group participants as by the therapist. This creates an atmosphere in which the individual has the freedom to move spontaneously back and forth not only between roles, but also between pure dance/movement expression and dramatic/dance-movement dialogue. Sometimes an emotion or insight experienced during a dramatic/dance-movement dialogue is integrated by the individual through pure dance improvisation. At other times the reverse may occur; after the improvisation, a theme concerning a particular relationship in the person's life may emerge through intense dance movements. Then the dramatic structure might be used to further clarify, shape, re-emphasize, or integrate the emotions being experienced.

Katharine. Some individuals who seek dance/movement therapy have been dancers and have learned to use movement in a controlled way to defend against, rather than to express, true feelings. The case of Katharine, a tall dark haired physical therapist in her mid-forties provides an example. Katharine had her body under excellent control through years of practicing yoga, dance, and figure skating. She moved in an elegant fashion, always keeping her head extremely high and her shoulders straight.

Feeling that drawing might help Katharine break away from her tight body control, Levy asked her to draw an animal. She drew a turtle which she described as living in the sewer. Then, when asked to make up a story about the turtle, she explained that he accepted the filthy, smelly sewer as his home and never experienced daylight. The turtle, she explained, felt helpless. He had been born in the sewer and there he remained; though he did not like it there and was never happy, he did not fight to get out. It was clear that through the drawing Katharine was expressing her true feelings about herself and the world.

In a dance improvisation which followed Katharine lowered her head and spine, walked around the room slowly with shoulders dropped for the first time, and fell to the floor in a womb-like position. Eventually, she drew one arm forward, palm up, and reached toward the therapist in a gesture of asking for help, crying out in the pain, loneliness, and isolation she had kept locked within for so long.

For Katharine, the drawing brought out a vulnerable aspect of her personality which she had previously defended against through tight body control and bravado. After releasing her emotions through the projective technique of drawing and then verbalizing these emotions at a level of abstraction she could handle (the animal in the sewer), she was able for the first time to allow her body to express her deeper feelings. In her movements she became the part of herself that was represented by the helpless animal in her drawing. However, in reaching out to the therapist for help, Katharine changed the end of the story.

The conflict Katharine had been unconsciously expressing through her physical rigidity was a conflict over expressivity. One part of her struggled to remain detached and aloof, and the other struggled to be expressive and "real." Interestingly, Katharine's internal drama emerged through the introduction of a second expressive modality (drawing). Hence, her drama became manifested in the interaction between her drawing self and her dance-movement self. In the sessions which followed, Katharine often referred back to this dichotomy and it became a paradigm for future dance-movement, artistic, and psychodramatic movement explorations.

In summary, the graphic arts used in combination with dance/movement, psychodrama and/or verbalization can facilitate the therapeutic process for some individuals. It can be used to ease a client into the dance/movement process, or to broaden and deepen the dance/movement experience. It can serve to provoke psychological material, providing the content (or preliminary script) for a dance-movement psychodrama, or to help clarify and crystallize any insights gained through dance improvisation or dramatic dialogue. Finally, drawing can act as a safety valve for highly charged emotions. In short, the graphic arts, when indicated, can be integrated into the psychodramatic movement experience in many different ways, providing an additional expressive medium through which conflicts can be explored.

Conclusion

Psychodramatic movement therapy is a creative action-oriented psychotherapy which incorporates a variety of expressive media: dance/movement, psychodrama and drama, graphic arts, and verbalization. Decisions as to which medium or media to use are based on the therapist's ability to intuit what experiences might be most helpful to a particular individual at a particular time. Naturally, there is no single sequence which will work for all individuals in treatment. The key is to allow individuals to move from idiom to idiom in a meaningful way, and the goal is to achieve a natural flow between the media forms and the clients' needs. The success of a session is determined not by the number of modalities used or the sequence in which they are used, but rather by the therapist's ability to be in deep empathic rapport with the client. It is this relationship that provides the foundation for healing and growth.

SECTION C

Dance Therapy With Other Patient Groups

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Dance Therapy in the Psychiatric Hospital Setting

One thing that has been discovered during this century of psychotherapy is that not all individuals can benefit from or express themselves through the verbal language. That is, for some, thoughts and feelings are or can be processed more fully when permitted somatic expression. One often finds this when working with psychiatric patients, who frequently have been hospitalized because people could not speak with them "in their language."

Marian Chace, the major pioneer, was the first to initiate direct communication with psychiatric patients via dance in the 1940's. Other early pioneers, notably Schoop and Rosen, began working with this population in the 1950's. Today hospitals and community mental health clinics throughout the United States are recognizing and including dance therapy as a part of their total treatment program for psychiatric patients. The following is a review of the literature dealing with this patient group.

The Therapist/Patient Relationship

The therapist/patient relationship is an essential part of dance therapy with all populations. With hospitalized psychiatric patients developing this relationship can be a particularly trying process, especially for new dance therapists. Susan Sandel (1980), a former student of Chace and an important writer in the field, believes that without self-examination, supervision and peer support, the new therapist may be prone to feelings of frustration, self-doubt and emotional exhaustion.

Emotional Stress on the Therapist

Working with hospitalized schizophrenic patients, Susan Sandel contends, is difficult and demanding, often with little to show in the way of progress and personal reward. In response to this it is not unusual for a new dance therapist to act in a defensive and/or compensatory manner to guard against feelings of anger and hopelessness. This denial is considered natural by Sandel and at times necessary if the therapist is to sustain his/her commitment to the treatment. However, Sandel warns, it is imperative that the new therapist understand how these same mechanisms may also be detrimental in a therapeutic situation.

For example, the therapist may see some glimpse of a behavior that he/she believes represents change or growth and may exaggerate the importance of this behavior. The danger here is that the therapist may think the patient is capable of more than is actually the case. These expectations often arise as a partial defense against frustration, but can in turn produce feelings of discouragement and anger when regression occurs. Sandel reminds us that schizophrenics demand intense emotional involvement and at times the dance therapist may feel he/she is being devoured by the patient's needs. Since in dance therapy the therapist and patient move together, frequently involving close physical contact, the therapist's deep emotional connection is a necessary part of the treatment. While deep empathy demonstrates an acceptance of the patient and may provide a glimpse into his/her inner world, it can leave the dance therapist feeling disoriented and depleted in addition to experiencing deep desires, even omnipotent thoughts of curing the patient. In essence, the dance therapist may find him/herself vacillating between feelings of omnipotence and despair. All of these reactions need sorting out if the dance therapist is to remain effective.

One form that transference takes for the schizophrenic patient is viewing the dance therapist as either the "good" or the "bad" mother. Sandel gives an example of each and discusses the resulting countertransference phenomena.

In one of her sessions, issues of the "good" mother and nurturance were acted out when a schizophrenic woman briefly sucked Sandel's thumb. At the close of the session, the patient was reluctant to talk about the incident but did say she may have been feeling like a baby. Later, with help from her psychotherapist, she realized that she wished Sandel was her mother.

Sandel felt that by tolerating and understanding her own anxiety resulting from countertransference feelings, she was better able to accept the patient's behavior without making it an uncomfortable issue for the patient. Hence the productiveness of the treatment was enhanced.

There will also be times when the dance therapist is viewed by the schizophrenic patient as the "bad" mother. At these times the patient may try to frustrate the dance therapist by refusing to dance. Sandel gives the example of one of her patients who lay face down on the floor throughout her sessions for more than a year. Nothing would rouse her. Each week the therapist would talk to the patient prior to the session asking her to join and the patient would say "OK," but then proceed to lie on the floor. One day, she stood up and began moving. After that day, still participating, she would remind the therapist of her prior behavior and say with a grin "It made you mad, didn't it?" (p. 28). Sandel experienced intense countertransference tensions resulting from the patient's earlier negative transference, that is, the bad mother. While she was pleased that the patient was now moving, each time the patient reminded her of her earlier resistance which had lasted one year, Sandel found herself experiencing fury. Both negative and positive transference phenomena produce stress for the therapist. Self-examination, supervision, and support are vital.

Finally, Sandel believes that schizophrenics are intuitively aware of the therapist's investment in his/her medium (dance) and his/her feelings of vulnerability as to the effectiveness of dance therapy as a treatment tool. A patient can lead a therapist to doubt his/her own value by a verbal attack, such as "This is dumb. It isn't therapy." The therapist must guard against defensive explanations and/or putting on a show as both behaviors expose the therapist's self-doubt, confuse the transference, and destroy objectivity in the treatment situation.

Joan Lavender's (1977) description of her work with Nick, a 43-year-old patient diagnosed as chronic undifferentiated schizophrenic, further illuminates the difficulties faced by new dance therapists trying hard to use their art therapeutically. Lavender's account traces not only Nick's progress, but also her own "growth as a young therapist learning to trust the dance process as a most powerful enhancer of the therapeutic relationship" (p. 123).

Lavender felt her work during the first year with Nick was "artless and mechanical" (p. 125), and the sessions were "either pre-structured and ineffectual, or chaotic, or both" (p. 126). She believed she was responding to Nick's movement strengths and weaknesses rather than seeing him as a whole person. Furthermore, she states:

> I distinctly felt that I was not yet using dance, but isolated and therefore awkward movement exercises instead. I could not get Nick to stop imitating my movements; but then, neither could I stop seeing him as an incomplete person. Because we both felt this inequality, we were not free to dance. (p. 127)

During the second year, the therapist-patient relationship began to grow, and as a result "the dancing deepened" (p. 128). Lavender played more of an emphatic role, moving with the patient and supporting his movement style. She became familiar with his movements and gestures, and with the meanings they conveyed. Later, she began to use her own variations in responding to his dance. The sessions were less contrived, and Nick began to create themes of his own. Improvisational dance was a major part of the sessions, and role-playing often emerged from it.

As the therapy continued into the third year, and the therapist-patient relationship continued to grow, Nick's self-confidence increased and he began to stand more upright. He also, at times, began to speak more coherently. As Lavender puts it, "word- thinking and movement thinking were becoming integrated" (p. 128).

Throughout her account of her work with this patient, Lavender stressed the importance of allowing the dance process to unfold naturally, and the patient's dependence on the dance therapist's comfort in the movement relationship.

> I came to understand that dance provides its own structure, according to the thoughts and feelings of the dancer. It is the emotional context of the dance that motivates the dancer to expand his/her movement-emotional world. Nick would assume his true height when something in the dance inspired him to unfold. He would breathe deeply only when the dance demanded it. He would command the space he moved through only when our dance would evoke such commanding feelings in him. A trusting relationship would nurture these new feelings. (p. 128).

Issues of Space and Separation/Individuation

Joan Naess (1982) discusses the link between the patient/therapist relationship and the developmental stages discussed in object relations theory. Although these stages are not always clear, she believes that understanding development can help to make sense of the intense feelings aroused in both patient and therapist in movement interaction. In the following case material, Naess' developmental framework is illustrated in two ways: through the growth of the relationship between patient and therapist (the author's primary interest), and through demonstration of the level of psychological functioning which the patient had attained.

The first case described Ann, age 23, diagnosed chronic undifferentiated schizophrenic. It was clear that Ann was in the autistic stage during her first dance therapy session. Her movements at this point were stretching, rolling, sliding, crawling, climbing, and collapsing. Ann made no attempt at eye contact and appeared to consider the presence of the therapist an intrusion. Future sessions appeared to be transitional. Although no eye contact was attempted, patient and therapist worked side by side, stretching and releasing. Ann spent months in this transitional stage, which Searles (1961) has called "ambivalent symbiosis," a period during which she wished for and yet was terrified of fusion with the therapist. The patient broke new ground for herself developmentally when she entered into the symbiotic stage, the point at which her maturation had previously been arrested. During this phase, Ann accepted eye and physical contact and began requesting back rubs. As the therapy progressed, Ann began to initiate push and pull movements with the therapist, suggesting, Naess believed, the beginning of the separation-individuation phase. Unfortunately, this coincided with her release from the hospital to a halfway house.

In the second case study, Naess described her work with Vera, age 21, diagnosed borderline personality disorder. Vera came from an old world "proper" background and felt isolated as she was considered a snob by the other patients. She appeared limp, depressed, and frightened with an overanxious desire to please. She felt unworthy of her relationship with Naess whom she overidealized.

Vera's autistic stage was short. She would stretch with the therapist or on her own, simply because she was asked to. She was not ready to communicate the feelings underneath the compliance. Slowly, by using relaxing music and lazy stretches, rolls, and curls, the facade began to fall away and Vera entered the symbiotic stage. At this time, she allowed the therapist to playfully slide her and eventually the two achieved synchronicity of movement while rocking, spinning, and expanding and contracting body shapes.

Vera was comfortable in symbiosis but had to be pushed by her dance/movement and verbal therapists to confront her good and bad object splitting in order to progress to the separation-individuation phase, her level of psychological arrest. Vera's entry into that phase became apparent when she began exploring her own body movements, expressing her emotions verbally and nonverbally, and becoming playful in the sessions.

Sandel (1982) also writes about patients' developmental stages, referring specifically to group dance therapy with schizophrenic patients. She finds numerous examples in the dance therapy literature of therapists forming symbiotic attachments with their regressed patients, using mirroring and rhythmically synchronous movements. Less attention has been devoted, she notes, to the therapeutic relationship with patients in the separation and individuation stage of development.

Citing the work of Kestenberg, Mahler, and Spitz, Sandel postulates that just as different mothering styles are required at the different stages of child development, so are varying therapeutic styles needed at different stages of patient development. However, because the early developments of the profession took place largely in work with the schizophrenic population, many "classic" dance therapy techniques Sandel postulates are based on the symbiotic needs of this population, but are less effective or even counterproductive when used with patients not in the symbiotic stage of development. Techniques such as the circle structure and continuous unison movement can block a patient's experiments in autonomy. Rather than signifying a "good" dance therapy session, a group of chronic schizophrenic patients moving synchronously in a circle may indicate excessive "dependence, compliance, and apathy." (p. 13).

In order to facilitate separation/individuation, Sandel (1982) makes the following suggestions. The technique of sharing the leadership role among the patients is ideal for fostering patient autonomy. However, this too can be subverted by the therapist if not done sensitively. If the therapist interrupts with strong verbal and movement suggestions to the patient "leader", the therapist will communicate that although she has delegated the leadership, she does not find the patient capable in this role.

The therapist may also intervene prematurely in an attempt to prevent boring or anxious moments. This does not allow the patient time to struggle with mastery, so he cannot learn and progress. On the other hand, the therapist should not abandon the patient, who depends upon his or her structure for a sense of safety and caring. It is indeed a delicate operation to provide a balance of support without intrusiveness.

Sandel points out that patients may be capable of participating in extended improvisations, requiring little external structure. They may work in small groups, lines, or around the entire room. They may pair off, preferring peer interaction to that with the therapist. They may ask for specific exercises for weight control and fitness. Role-playing and dramatic techniques may also be used to foster differentiation, through practicing assertive behavior and experimenting with unfamiliar situations and roles.

The importance of personal space is also pointed out by Sandel (1973), who stresses that the therapist must respond to the patient's need for distance after periods of intimacy. Bovard-Taylor and Draganosky (1979) have also written of the importance of personal space in fostering both the therapist/patient relationship and the therapeutic process. From their clinical experiences, they make the following suggestions: 1) allow the patient/client to feel that he/she can be in control of the space; 2) be sensitive to changes; 3) be alert to misunderstandings; 4) accommodate personal space preferences; and 5) respond verbally or non-verbally to signs of comfort or discomfort.

The Case of Jay

In a case study, Arlynne Stark (Samuels, 1972) discusses how Sharon Chaiklin helped a patient to break through his isolation, express his emotions, take control of his personal space, and relate to his environment. Jay was a 21-year-old black male whose diagnosis was catatonic schizophrenia and mental retardation. According to tests, he was mentally four years, five months old. He attended individual sessions for three months, one hour weekly.

Chaiklin's work focused on the following physical goals: helping Jay to move with more strength and quickness; encouraging deeper breathing; improving his ability to control his body; relaxing his physical defenses; and encouraging his use of verbalization. Through the therapeutic relationship Chaiklin was attempting to bring him out of his withdrawal and reduce his emotional defenses and physical rigidity.

Jay kept his eyes closed and his body rigid and was mute in the beginning of sessions. His process in the therapy was like a puzzle being put together. Through the twelve sessions, the rigidity of each body part was unlocked, until the whole could move fluidly and in unison. The following is an overview of this process.

Chaiklin focused first on the strength and depth of the patient's breathing. Soon he initiated the breathing exercises himself, and by the fifth session was able to breathe out with force and strength.

She used many props to increase the range of the patient's movements. She explained that initially she chose to use props because of the patient's ostensibly low IQ. As they worked together, she came to regard the patient's impairment as emotional rather than cognitive in origin, and exacerbated by lack of education. However, she continued the use of props because the patient responded well to them, creating games and increasing his use of space. A stretch rope, for example, gave him his first opportunity to stretch his arms out to each side; hoops were used to rotate and relax his tense right arm, and became the basis of the "space game" wherein he and Chaiklin attempted to block each other in moving around the room. Streamers encouraged rhythmic fluid movement, and balloons called attention to the grasping motion of the fingers. Props also encouraged the patient to keep his eyes open throughout the session—he had to watch where the hoop descended in order to catch it in mid-air.

As his relationship with the therapist deepened, he allowed himself to use strength to push and pull with his hands against hers, or to lean against her and sway gently to the music. Eventually (session six) he began to assert himself, not allowing her to move him further than he wished, using his weight to say "no." Chaiklin encouraged Jay to create his own meaningful space through his movement interactions with her. Her respect for his special needs helped Jay to trust the therapeutic relationship. She encouraged him to express both his needs for closeness and distance.

At about session seven, pure movement gave way to affect. The patient entered the room swishing and talked during the session. In the succeeding sessions, he laughed, cried, and showed a range of feelings in his facial expressions for the first time.

In the last session of the study, Jay had begun to manipulate his movements to control his feelings, realizing that when a feeling surfaced from a movement, he could change the movement to change the feeling. He no longer had to resort to totally blocking out the environment by closing his eyes and making his body rigid. With Chaiklin's help he learned that he could be in charge of himself. Chaiklin gave him room to push, pull, lean, sway, block, grasp, and stretch, all forms of defining and regulating his personal space and hence himself. Individual work with Jay continued after the twelve sessions of the study. Two months later he was able to participate in a news film demonstrating dance therapy.

Group Interaction

Group work with psychiatric patients revolves around interaction among group members as well as the dance therapist's relationship with each patient and with the group as a whole. Helene Lefco's (1974) work with a group of six adolescent psychiatric patients in an in-patient private clinic setting provides an illustration of the group process.

Lefco begins with two group structures only, the circle formation and warm-up movements. After this the spontaneous group interaction takes over and Lefco seems to ride the crest of the group's emotional wave.

For example, Lefco describes a dramatic scene where the patients, frustrated by their own emotional needs, spontaneously began to imitate one of the group members, Laura, an obese patient. The group proceeded to act out, through dramatic movement, the desire to gorge themselves with food. Laura, at first reticent, eventually joined in. After much aggressive

Movement Observation Scale

By Arlynne Samuels* and Sharon Chaiklin

Effort-Flow (tension of the movement)

Bound$_1$ ______________ $_5$Free

Free$_1$ ______________ $_5$Bound

Does it change from free to bound ______________

Does it change from bound to free ______________

Burst Flow ______________

Sustained ______________

Efforts**

Space:

Direct (straight, undeviating, channelled$_1$ ______________ $_5$

Indirect (spiralling, flexible)$_1$ ______________ $_5$

Time:

Slow (sustained, lingering)^1 ______________ $_5$

Quick (sudden, instantaneous)$_1$ ______________ $_5$

Force:

Strong (forceful, vigorous)$_1$ ______________ $_5$

Light (weightless, buoyant)$_1$ ______________ $_5$

Shape-Flow (movements occuring towards or away from the body)

In to out ______________

Out to in ______________

Shape

Rising (ascending) ______________

Sinking (descending) ______________

Widening (spreading, expanding) ______________

Narrowing ______________

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*Arlynne Samuels—now known as Arlynne Stark

**Stark & Chaiklin would update this scale by delineating degree of effort from frequency of efforts hence adding another category to their scale.

Advancing (progressing forward) ____________ ____________

Retreating (withdrawing) ____________

Path in Space

One phasic (linear movement using only one plane) ____________

Reversal ____________

Two Phasic (curved, uses two planes) ____________

Sculptured (spiraled, three planes) ____________

Planes

	Primary Stress	Secondary Stress
Vertical ____________	Up and Down ____________	Side to Side ____________
Horizontal ____________		
Sagittal ____________	Side to Side ____________	Forward/Bkwd ____________
	Forward/Bkwd ____________	Up and Down ____________

Body Attitude (the qualities which are maintained in the body, out of which movement occurs)

Narrow ____________

Neutral ____________

Wide ____________

Sunk ____________

Other ____________

Kinesphere (the limits of an individual's space around his body)

Small$_1$ ____________ $_5$Large

Specific Areas:

High ____________	Forward ____________
Middle ____________	Side ____________
Low ____________	Back ____________

Gesture (movement of one part of the body)/Posture
(movements which spread through and involve the entire body)

Gesture$_1$ ____________ $_5$

Posture$_1$ ____________ $_5$

Begins Posturally to Gesture ____________

Begins Gesturally to Posture ________________

Ratio of Change ________________

Area of Body in which Movement Occurs

Hands ________________

Feet ________________

Legs ________________

Arms ________________

Head ________________

Trunk ________________

Eye Contact

None$_1$ ________________ $_5$Total

Trunk Involvement (how trunk area is used)

One Unit ________________

One Unit, Vertical Stress ________________

Two Unit-Top Rigid ________________ Bottom Rigid ________________

Body Axis Spreading (opening, widening) ________________

Upper against lower with twist ________________

Upper against lower without twist ________________

Is trunk being used Congruently ________________ Incongruently ________________

Does not apply ________________

Tension Areas

Face ________________ Mouth ________________ Jaw ________________

Neck ________________

Shoulders ________________

Chest ________________

Back ________________

Mid-Section ________________

Pelvic ________________

Arms ________________

Hands ________________

Fingers ________________

Legs ________________

Rhythm (Synchromy of body parts)

Dissynchronous$_1$ ________________ $_5$Synchronous

Energy Level

1 ________________ 5

Amount of Expressiveness (quantitative expression of feelings through movement)

Limited$_1$ ________________ $_5$Extensive

Kind of Expression (qualitative)

1 ________________ 5

Frequency of Spontaneity

1 ________________ 5

Relating to Others

Unresponsive$_1$ ________________ $_5$Responsive

Does Not Initiate$_1$ ________________ $_5$Initiates

exaggeration of oral needs were acted out in unison, the group settled into a more passive contented state which included rocking and sucking movements. "The room was quiet except for the subtle sounds of the music, and the hungry suck of baby's mouths" (pp. 35–36).

The creative and spontaneous aspect of Lefco's work presents itself most potently in the simultaneous interplay of dance and dramatic action with the ongoing verbal dialogue among the group participants. Lefco also interacts spontaneously, reflecting both verbally and nonverbally the feelings group members are expressing. She quickly changes the music to facilitate and accommodate the expression of feeling. Lefco's work reflects her courage in meeting the challenge of the unforeseen moment, and giving the group a great deal of latitude for personal expression without judgment. She then creatively deals with the results of her permissive group structure.

Lefco's work is unique in that it is done in a small group setting at a private clinic located on acres of farmland, where the patients and staff lived together as a family unit in small trailers. At the clinic, drugs and shock therapy are not part of the patients' treatment. This is significant in that many dance therapists have experienced the reliance on chemotherapy and shock treatment in some hospital settings as a hindrance to the dance therapy process, often rendering patients so lethargic that they have little energy left for body movement or self- expression.

Structural Analysis of Group Dance Therapy

David Johnson and Susan Sandel (1977) developed a system called the Structural Analysis of Movement Sessions (SAMS), which grew out of their work with adult psychiatric patients in dance and drama therapy groups. Johnson and Sandel describe SAMS as "both a vocabulary of group events and a method of analyzing aspects of the group's functioning" (p. 32). It is an important and unique contribution in that it focuses on the structural aspects of the group (i.e., the patterns of group activities) rather than on the content (i.e., what the activities are). The authors believe that generally the therapist tends to determine the structure while the participants define the content. Thus, "by analyzing and categorizing these structures," SAMS "may provide the therapist with a useful framework for thinking about his/her interventions" (p. 33). Specifically, SAMS defines 46 kinds of structures which are divided into Task ("the observable action and sound patterns of the group as a whole"), Space ("the physical relationship which the group members have to one another, i.e., the group formation"), and Role ("the particular pattern of formal roles that the group sets up in conducting the activity") (p. 33).

Johnson and Sandel then go on to describe its use in analyzing two dance therapy groups, both consisting of hospitalized psychiatric patients. They conclude:

> While SAMS has potential as a research device, perhaps its greatest immediate benefit to dance and drama therapy may be as a system for observing and thinking about groups, and how they are functioning. It is our belief that SAMS has helped us in improving our clinical acuity and it has certainly helped us in communicating more clearly what occurs in our sessions. SAMS might provide valuable data for therapists in training to use in developing their group leadership skills. As it focuses attention on disruptions in the flow of the session, SAMS may help the therapist identify when such disruptions begin to occur, and decide how to deal with them. . . . (p. 36)

Johnson, Sandel, and Bruno (1984) used SAMS to compare the efficiency of different amounts and types of structure in dance/movement therapy groups with three populations: schizophrenic, character-disordered, and normal. The authors' previous clinical observations had shown them that schizophrenic and character-disordered patients, often grouped together on a hospital unit, responded differently to the undifferentiated structure and flexible rules of the "classic" style dance/movement therapy group.

Their hypothesis was that schizophrenics, who tend to "have difficulties in maintaining clear . . . boundaries in their thinking and interpersonal relationships," (p. 417) would show a higher activity level in a dance/movement therapy session with less differentiated structure and tasks. Character-disordered patients, who tend to have "rigid, inflexible ego boundaries" would show a higher activity level in a session with clear differentiation and structured tasks. Normal subjects, with whom most previous research had dealt, would be active in both types of session structure.

Three different therapists led one group of each population (schizophrenia, character disordered, normal) in two dance/movement therapy sessions. Session 1 was highly differentiated, using games with rules, a cloth prop, and a specific order of activities. Session 2 was less differentiated, using spontaneous movement and development of images. Use of the circle and rhythmic unison movement were the only pre-planned aspects.

The videotapes were scored using SAMS. The results were consistent with the authors' expectations. The character- disordered groups responded to the less differentiated session by dropping out, "challenging the therapist to set limits" (p. 426), or getting into conflicts with each other. They did not want to hold hands or stay in the circle. The authors believe these behaviors were motivated by the patients' fears of fusion and anxiety about intimacy.

The schizophrenic patients became more anxious in the more differentiated sessions. The rules confused them, while the character-disordered patients had made up new rules of their own.

The normal groups seemed most concerned with what was expected of them. Although they were bored by the less differentiated session, they did not disrupt it.

The authors suggest that useful structures for the character- disordered population are: games with structured comings and goings from the circle; pair as well as whole group interaction; and competitive, not unison, activities. They believe that the structure of the group affects the therapist's efficiency, in that:

> Disruptive challenges to the therapist's leadership will probably be diminished if authority is located in complex rules rather than in the person of the therapist. (p. 427)

In another study, the leadership styles of dance therapists and their subsequent effects on normal, schizophrenic, and character- disordered groups was the subject of a study by Johnson, Sandel, and Eicher (1983). The authors do not believe that analysis of transference and counter-transference phenomena alone can explain the patient's perception of and reaction to the dance therapist.

In the dance therapist's role as a group leader, he or she serves many managerial functions, including:

1) maintaining the external group boundary;
2) mediating the level of complexity in the group's tasks;
3) controlling the group interaction; and
4) tolerating ambiguity and uncertainty. (p. 17)

Being in the unique position of facilitating therapy via a broad spectrum of action-oriented activities, the dance therapist is required to manage ever-changing group spatial arrangements and leader/follower roles. Thus, the individual in the dance therapy group (perhaps more than in verbal therapy groups) has a genuine reaction to the dance therapist as a group manager.

Using SAMS, the authors analyzed the reactions of the three patient groups to the management styles of three dance therapists and found a correlation between diagnostic category and preferred management styles. The findings corresponded with those of the 1984 study, discussed above, concerning the effects of different types of group structure. For example, the schizophrenic group preferred leadership styles which evoked a well-defined, intimate social milieu, whereas the character-disordered patients preferred groups that avoided fusion and ambiguity. The authors speculate that the managerial style of the group leader evokes patterns of responses from participants "based on the degree to which the group corresponds to internalized configurations of familial interaction." (p. 28)

The overriding goal of the study appears to be less in establishing guidelines for dance therapy with specific patient populations than in clarifying the complex role the dance therapist plays transferentially and managerially. Johnson, Sandel, and Eicher believe that "leadership style is a relatively stable configuration of behavior unless the therapist is actively and consciously attempting to alter it." (p. 29) They conclude that the effectiveness of the dance therapy group can be enhanced through a deeper awareness by the dance therapist or his/her personal leadership style and its impact on different patient populations.

In another study, Sandel and Johnson (1983) examined group work with severely disturbed schizophrenic and geriatric patients, believing that groups with severely disordered patients are substantially different from groups of higher functioning populations. The primary difference is a lack of group identity. Patients are so disoriented that they "often remain silent, do not know why they are there, or feel that they have been forced to come for no reason." (p. 131) Because they do not hold an internal representation of the group, members cannot "become socialized . . . to the group culture," lending their energies to help each other change. Thus, the therapist becomes the "container" of the group identity, since only he or she can connect to the participants in the group, and to reality, and can maintain a mental image of the group as a "group."

This places enormous pressure on the therapist who may react in a number of ways. He or she may become depressed before each group begins, knowing that without his/her presence, the group would disappear entirely! During the group, the therapist may be hypersensitive to any nuance of changing patient behavior, viewing it as a sign of progress. An outside observer would not even notice the change. After the group, the therapist may spend a great deal of time "processing" what happened, comparing it to the various theories, in order to reinforce his/her sense that the group really exists.

The authors coined the term "nascent groups," (1983) connoting that their organization does not resemble groups usually discussed in the literature. They find that the group structure is stable, but that it does not develop, rarely even approaching the early formative stage of the other groups. The therapist's reactions to the group's characteristics are included as an essential part of the description of an experimental "nascent" group. The following is a discussion of the progression, of a nascent group, using SAMS.

The authors organized and videotaped a ten-session dance therapy group with twelve hospitalized schizophrenic patients. They then analyzed the sessions using SAMS, along with clinical observations obtained through the therapists' process notes, questionnaires, and videotaped analyses.

The patients ranged in age from 31 to 60, and had been hospitalized numerous times for 10-30 years. None received intensive therapy. All were dishevelled.

All forms of clinical analysis showed that the ten sessions fell into three distinct phases. The first phase showed patients and therapists on their best behavior. The patients were compliant and curious about their new therapists. In the first session, the therapist served as the focus of attention as the patients touched her face and smelled her hair. Therapists were optimistic and enthusiastic.

In the second session, several of the male patients had responded to the videotaping by washing, shaving, and dressing neatly. In the movement, aggression was expressed through kicking, with images of people upon whom the patients had been dependent in their lives.

Phase II began in the third session with the collapse of Phase I's high hopes. One patient dropped out, several resisted coming to the group; two men returned to their dirty, unshaven state. Movement included a tug of war game, and unison walking around the circle with tiny steps.

The second phase comprised the heart of the therapeutic work, as group members struggled to relate to each other. The authors' comment:

> Each advance toward intimacy was followed by a temporary retreat into unrelatedness, distancing, and disruption of the sessions. (p. 136)

In session four, group members appeared to be aware of each other as individuals for the first time. They introduced themselves to each other in words and movements; they symbolically made a "fish stew", each member adding an imaginary ingredient.

Members retreated from the intimacy in session five by coming late to the session or, in several cases, refusing to come at all. The therapist felt pressured to entertain the patients. All were relieved to draw, in an exercise at the end of the session, which decreased the interpersonal contact.

The group moved toward intimacy again in session six with increased touching, and a discussion of how difficult it is to maintain friendships in the hospital. One member acted out the group's anxiety over this closeness by behaving in a bizarre fashion. The author's interpretation of this was that the individual, not able to accept the group's intimacy, attempted to break up the experience and in so doing acted out the feelings of other group members as well.

In session seven, the therapists were active, pushing for greater interpersonal gains, but the patients were happy with simple synchronous movements. Several times they returned to the circle formation without direction from the therapist. The therapist initiated the image of building a sand castle; the patients changed it to a "sand pit" in which they could be buried. The authors' interpreted this as the patients preferring fusion to the therapist's push for differentiation.

The eighth session preceded Easter vacation week when the group would not be meeting. Although the mood of the group was sad, the patients engaged in their highest level of closeness—doing deep breathing and giving each back rubs.

The ninth and tenth sessions marked the termination of "dissolution" phase. Many members refused to come to the ninth session. A plastic sheet became "quicksand" which was unsafe to cross, as one could be "lost forever." The last session was chaotic, becoming organized only around the coffee and cake served at the end.

With prolonged contact with a caring therapist in a stable milieu, severely disturbed patients can begin to interrelate; functioning is stabilized and atrophy stopped. These groups must be regarded as long-term support systems, rather than as short-term intervention which will resolve problems.

> Even framing these groups as initial steps in a developmental process which will lead eventually to a higher level offers unwarranted optimism, and serves to deny the truly distinct process and organization within these groups. (p. 139)

Summary

Dance therapists generally stress the importance of the therapist/patient relationship in fostering growth for hospitalized patients, particularly when working in individual sessions. In group work, the importance of experimenting with various types of group structures and therapist leadership styles has also been emphasized. Special attention has been placed on the many emotional stresses which this population places on the dance therapist, particularly stemming from transference and counter transference feelings.

In general, dance therapy with hospitalized psychiatric patients focuses on promoting body image, interaction, communication, and self-expression. These goals coincide with the physical, social, and emotional goals described by the early pioneers of dance therapy.

18

Dance Therapy With The Special Child

The use of dance with children as a creative form for self-expression and as a means of organizing thoughts and feelings into form and content was being discussed by dance educators, dance researchers, and clinicians in the mid-twentieth century. Franziska Boas was practicing dance therapy with hospitalized children as far back as the 1940's. However, it was not until the 1960's that "dance therapy," as a professional practice, became a recognized and respected route of therapeutic intervention for children with special problems.

Miriam Puder's (1972) master's thesis presents a general overview of the discipline of dance therapy with the special child. In this study Puder interviewed 20 dance therapists, many of whom were well known for their contributions to the practice of dance therapy with this patient population. Of the 20 interviewed by Puder, 15 were also observed directly during dance therapy sessions. From her investigations Puder made the following general statements regarding the similarities and differences among the dance therapists she interviewed and/or observed. Concerning the similarities, she found that: 1) most dance therapists have a strong dance background; 2) dance therapists use verbalizations extensively; 3) physical touch and praise are common aspects of treatment; 4) the experience of joy and pleasure are important elements of sessions; 5) a positive relationship with the dance therapist is viewed as central to the therapy process; and 6) dance therapists working with this patient group place primary stress on the development of the body image.

In regard to the differences, Puder notes that dance therapists vary in: 1) the degree of structure versus non-structure of dance therapy sessions; 2) the role the therapist plays either as directive or non-directive; 3) the percentage of time the dance therapist uses music, if at all; and 4) in their stress on either cognitive or emotional development. The first two differences noted by Puder seem to overlap, and interestingly, are the same differences amongst therapists practicing in the late 1950's (see Discussion, Unit I).

Many of the same similarities and differences can be found among the dance therapists whose work with special children is surveyed in this chapter. While the following discussion is generally organized according to the diagnosis of the children, the lines of division are not always clear cut, as children's diagnoses are often complex and overlapping. Some consideration was also given to the theoretical emphasis of the dance therapist but again, lines could not be clearly drawn.

Autistic Children

Autistic children are often described as living in their own world. They shun human contact, are unable to relate meaningfully to others or to the environment, and frequently engage in ideosyncratic movement patterns. While approaches vary, the dance therapist whose articles are reviewed here stress the need to reach these children at their own developmental level, that is the primitive sensory-motor level. Through the use of techniques such as reflecting, sharing, and mirroring the child's movements, the dance therapist creates "... .a dance which is reassuring in its familiarity and implicit acceptance of the child" (ADTA, n.d., p. 5). This leads to the development of trust and the formation of a relationship between therapist and child.

Beth Kalish-Weiss, psychologist and dance therapist, received her original dance therapy training in New York City with Marian Chace in the training sessions at Turtle Bay Music School in the 1960's. Like other early leaders in that class, notably Schmais and White, Kalish-Weiss went on to study with Irmgard Bartenieff. However, whereas many of the early Chace disciples went on to broaden and clarify the Chace technique with the hospitalized psychiatric patient population, Kalish-Weiss was particularly concerned with the psychodynamic make-up and movement behavior of the autistic child. This interest led her to pioneer as a dance therapist with this special group. Kalish-Weiss theoretical, practical, and diagnostic contributions to this population are the topics of the following discussion.

In the mid-1960's, Kalish-Weiss explored her unique interest in the movement characteristics and treatment of autistic children, believing that these children could be reached most effectively through non-verbal means. Feeling there was a need for a systematic way of measuring the non-verbal communications of the autistic child, she set out to create a movement scale "which could be learned and applied by anyone on a regular basis, in a clinical setting, for use with non-verbal, 'untestable' psychotic children" (1976, p. 126).

In 1971, Kalish-Weiss introduced the Body Movement Scale (BMS), one of the eight scales of the Behavior Rating Instrument for Autistic and Other Atypical Children (BRIAAC).[1] Each of the eight scales, including BMS, notes the successive behavioral changes in a child's progress towards more adequate psychological functioning. The overall goal of BRIAAC is to provide a universal language of movement terms (Kalish, 1974a). The knowledge of atypical behaviors gained through the use of BRIAAC can guide the therapist in assessing the needs of a child and in planning therapeutic intervention.

Kalish-Weiss (Kalish, 1976) developed and designed the Body Movement Scale using effort/shape terminology and incorporated many of the theories of Laban and his protegés concerning how to observe movements. The theoretical basis of BMS also includes: Kestenberg's tension-flow system; Freud's body movement theory of function and adaptability; the works of Ruttenberg, Dratman, and Teitlebaum concerning the delayed, slow motion development of autistic children; as well as the theories of Hunt and Allport (Kalish, 1974a).

It was Kalish-Weiss' assumption, as well as her motivation for developing this scale, that "movement behaviors would reveal developmental data about the non-verbal child if a method could be found to measure these behaviors reliably" (Kalish, 1976, p. 126). Furthermore, she believed that:

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[1] The other seven scales of BRIAAC are: Relationship; Communication, Vocalization; Speech and Sound Reception; Social Functioning; Psychosexual Development; and, Drive for Mastery

> . . .the movement dimension had been used only in a superficial and fragmented way in therapy with non-verbal children. It seemed that a movement scale, when thoroughly learned and understood by clinicians (who usually rely so heavily on verbal techniques), could offer some new directions for therapeutic interaction and interpretation. (Kalish, 1976, p. 126)

The goal of the Body Movement Scale is to specify body movement patterns in autistic children, and qualities of those patterns, which are significant in the process of maturation. BMS "attempts to place the 'pure movements' in a developmental framework based on empirical observations of both normal and atypical (autistic) children, and how they move" (Kalish, 1976, p. 6).

Thus, the Body Movement Scale provides a systematic way of assessing the non-verbal communications of the autistic child. The dance therapist can then use this information to personally experience and reflect these communications, and thus reach the child at his/her own physical developmental level. Kalish-Weiss (1976) stresses the need for therapists to experience the child's movements in their own bodies so that they can be used as a means of communication.

> Although the goals of the movement therapist are similar to other psychotherapies using body contact, the methodology is slightly different in that the movement therapist uses her own body movements, sounds, rhythms, as well as touch, to gain the child's attention, establish an emotional relationship, and offer pleasurable opportunities for reciprocal interaction. (Kalish, 1976, p. 91)

In order for dance/movement therapists to effectively use their own bodies in interacting with the child, it is necessary, Kalish-Weiss notes (Kalish, 1969) for them to be familiar with their own movement repertoire. She points out that sharing and mirroring movements is extremely delicate with autistic children. If the therapist intervenes too much, the child will probably withdraw immediately; if there is not enough intervention, the child cannot be reached. For this reason therapists must be adept at picking out the essence of movement patterns, since this is really what the child responds to, and since it is not possible for anyone to exactly replicate the autistic child's unique movement patterns (1968).

Kalish-Weiss stresses three important demands placed on the dance therapist: 1) to observe the child's non-verbal communications; 2) to know his/her own non-verbal communications; and 3) to find a point at which his/her own body movements can communicate with the child's body movements, hence promoting communication and interaction on a movement level.

This philosophy is reflected in Kalish-Weiss' clinical practice. The following quote from her 1967 article written with Dratman (one of the originators of BRIAAC) demonstrates how the therapist uses her own body movements to relate to the autistic child at the child's own developmental level. One sees here Kalish-Weiss' therapeutic stress on the developmental progression from the early symbiotic phase, when the child is merged with the adult, to the separation-individuation phase (Mahler, 1968).

> She [the therapist] takes the child where she finds him and tries to become one with him. She mirrors and imitates what he does until the child is comfortable with her—and she attempts to be his body double—with all his disturbance and his withdrawl—his autism.

> She practices blendsmanship, to coin a phrase. Then slowly she changes just one small part of the space and rhythm around him. (Dratman, 1967, p. 44)

At this point, the separation-individuation phase is introduced.

> Where he ends and she starts he doesn't know and after many weeks or months she [the therapist] slowly disentangles herself—*very slowly*. . . . Gradually he recognizes her as an entity, sees where he begins and she starts. In the same way as a mother feeding her child—or holding her child—does with a movement, a look, a sign, a touch, which impinges on her child a thousand times during a day. . . . The dance therapist also does it thousands of times with the child until he is within her narcissistic milieu and a transfer of emotions . . . takes place from her to him. This allows the child to slowly become aware of his own arm, or finger, or leg in a way much different from before. (Dratman, 1967, p. 44)

Once trust is established by reaching the child at his/her developmental level, Kalish-Weiss (1968) stresses the need to build the child's body image. She believes the autistic child, who has never formed an intrapsychic representation of his/her body, can develop more normally once a sense of self is achieved.

Forms of intervention used by Kalish-Weiss include using her own body movements as stimuli, and exploring with the child his/her own rhythms and accompanying vocalizations and body actions, also helping the child to move independently, to externalize aggressive energy, and to accept human contact.

Kalish-Weiss' (1982, unpublished) case study of Ana, an autistic and multiply handicapped child, illustrates aspects of her approach. A genetic disorder, Di George Syndrome, discovered shortly after Ana's birth, forced doctors to perform several life-saving surgical procedures during the postnatal period. Her labored breathing was relieved somewhat by a tracheotomy, and she had to be fed through a tube leading to her stomach. She was rescued from heart failure. Her thymus gland was missing, and thymus substance had to be surgically implanted.

When Ana was finally taken home, her mother soon noticed that she didn't smile, respond to sounds, or demonstrate normal four-month-old playfulness and curiosity. When Ana was picked up, she would stiffen her body and arch her back or go completely limp. She made no eye contact with others.

Her parents, suspecting autism, had her evaluated. She was immediately discovered to be profoundly deaf. She was fitted for bilateral hearing aids, but would not tolerate them.

Enrolled in an infant-toddler program for the handicapped, Ana did not interact or make eye contact with anyone and spent most of her time lying on the floor, flipping her hand rhythmically against the side of her head. She scrupulously avoided physical contact or proximity to others, pushing them away or rolling away from them. Her parents and teacher were very discouraged.

At two years, four months of age, Ana was referred to Kalish-Weiss for body movement therapy. Kalish-Weiss hypothesized that the active quality of Ana's resistance to people and things was a sign of ego strength. She hoped to use movement and play to offer the child more pleasant experiences than she had had thus far. If the child could be motivated to crawl, roll, and play hand games in interaction with others, she might develop a sense of her own mastery and ego controls and move out of the autistic-like stage to the next stage of symbiosis with her mother.

With Kalish-Weiss' support and guidance Ana's mother became her co-therapist during therapy sessions and at home. Ana's mother experimented with new ways of holding and positioning the child to encourage greater physical mastery and more eye contact. She played actively with Ana, but also learned to hover over her less, encouraging the child to actively seek out her mother when she needed or wanted her. She moved Ana out of the master bedroom into a separate room equipped with an intercom so that Ana could be heard if her tracheotomy needed suctioning during the night.

After a few movement therapy sessions, it became clear that Ana was learning to differentiate between her mother and the therapist. Ana was also becoming more inquisitive about her environment, and smiled briefly when moved using Ana's rhythms. Interestingly, during this period, her tracheotomy needed suctioning far less frequently than before.

As sessions continued, Ana's face would brighten when she approached the therapy room. She would wriggle out of her mother's arms and study herself in a large three-way mirror, moving her head from side to side. She crawled eagerly now, and was delighted when Kalish-Weiss crawled eagerly now, and was delighted when Kalish-Weiss crawled with her. Her mother and the therapist both began to suspect that she was hearing sounds. (Autistic children frequently lose their "deafness" as they learn to seek out and make rewarding contact with the people and objects around them.)

The therapist's modeling of how to play with Ana was instructive and encouraging for the mother. She was gratified to see someone having fun with her child. She learned to relax more with her daughter and to enjoy interacting with her. These attitudes and skills were carried back into the home environment, and contributed significantly to the overall success of the therapy.

After three months of therapy, Ana's functioning was evaluated using the BRIAAC scale. Although the assessment clearly showed that Ana had made progress, she was still functioning primarily in the autistic range, performing at about one-half her age level.

Kalish-Weiss subsequently decided to try working alone with Ana, feeling that the child might feel comfortable and secure enough with her to allow the mother to leave for a while. The experiment was successful. Ana's attention span increased and her movement behaviors were more directive. She would indicate which games she enjoyed the most and direct the therapist to repeat them.

One day, Ana was missing her mother. She crawled over to her mother's handbag, pulled out the car keys, and brought them to Kalish-Weiss as if to say, "Where's Mom? I'm ready to go now." She was learning to communicate.

A second BRIAAC rating was done shortly thereafter, and showed marked progress since the previous assessment. An audiology test showed that Ana was, in fact, beginning to hear. She would now tolerate hearing aids for short periods.

A third BRIAAC rating, done about six months after the second, showed continued, encouraging progress, especially in the areas of body movement, sound reception and relationship building. There can be little question that movement therapy intervention was one of the primary factors in stimulating Ana's developmental gains over a ten-month time span. And the BRIAAC scale provided a valuable tool for assessing her functioning and documenting her progress.

In another case study, Janet Adler (1968) describes how the development of a three-year old autistic girl named Amy during two months of therapy corresponded with the developmental stages in an infant's first nine months of postnatal life. That is, first she began to explore the therapist's body as the infant explores the mother's body. Later, she began to explore her own body, and finally she started imitating the therapist.

By allowing the child to regress during sessions, Adler helped Amy to move through the early stages of infancy and toward a more developed style of interaction. As Amy was able to tolerate more physical contact with Adler she demonstrated a simultaneous reduction of autistic gestures, Adler's work with Amy, similar to the work of Kalish-Weiss, focused on the use of reflection and synchronous movement interactions. Both dance therapists emphasize the importance of responding empathetically to the child, that is, experiencing what the child experiences.

Adler's work with Amy and the well-known film "Looking for Me" depicting this case have become landmark contributions to the practice of dance therapy with autistic children.

Maureen Costonis (1978) describes her use of synchronous movement with an unmanageable five-year-old autistic child named Patricia. The specific goal was to determine whether Patricia was capable of imitating, an important and basic component of the learning process.

Costonis developed the Synchronous Movement Profile (SMP) to measure changes in the amount of synchronous movement during dance sessions. "The data are indicative of the growing ability of an alienated and disaffected child to establish contact with another person" (p. 7).

The SMP is divided into five areas of observation: head, torso, hands, arms, and legs. The observer scores each as follows: 1) 2 points for synchronous movement, when "the subject's angles of rotational or plane movement of any of these body parts are virtually identical to those angles of the dance therapist's"; 2) 1 point for approximate synchrony, when "a body part is within a forty-five degree angle but not moving in the identical pathways of the dance therapist"; and, 3) no points for nonsynchronous movements, when "the subject's and dance therapist's angles of movement are differentiated by more than forty-five degrees" (p. 8).

The observer spends 5 seconds out of 60 watching the movement of the subject and therapist, and the remaining 55 seconds recording these observations. In addition, the movement sessions were videotaped for more accurate scoring. Costonis describes the SMP as a reliable alternative to effort/shape scoring.

The SMP revealed that Patricia's ability to move synchronously improved drastically over the ten sessions. It also suggested that synchronous movement can be learned with practice. Nevertheless, Costonis stressed that her goal was to test the child's imitative behavior, not to teach her how to mimic. The progress made by this child during the period of dance therapy with Costonis revealed that she was capable of imitation and that she had an ability to learn.

Another dance therapy approach that has been used with this population is based on psychoanalytic concepts. Elaine Siegel, Betty Blau, Linda Salz-Citron, Rose Schenck, and Patty Schmitt (1980) describe their work with four autistic children using this approach. At first, behavior is evaluated symptomatically. Developmental disabilities are given priority over intrapsychic conflict. "The emphasis is first and foremost on the improvement of functioning" (p. 63). There are two modes of intervention. The first is in the form of weekly classroom sessions. Here the focus is on remediating deficits in motor skills as revealed through the Oseretsky Test for Motor Proficiency. Movements are prescribed according to specific aims. For example, if the goal is socialization, a movement prescription might be a folk dance. The second mode of intervention is in the form of individual therapy in addition to the classroom sessions. These are held twice a week. Here the emphasis is on "the widening of the conflict-free ego-sphere (Hartman, 1958), that is, broadening and strengthening those parts of the ego already free of conflict, and the building of a trustful interrelationship, with a positive transference to the therapist" (p. 64).

For some individuals movement therapy is assigned as the primary therapy. In these cases:

> symptomatic behavior is viewed as an expression of conflict in the entire person and as indicative of fixations at developmental levels lower than those expectable at the given chronological age. Here the development of a positive transference is still the goal, but the interaction that develops often moves toward part-object relationships as defined by Mahler (1968), Searles (1963), [and] Winnicott (1953) . . . until true symbiosis and, eventually, individuation occur. (p. 65)

During this period, the therapist stresses the expanding of existing skills and cognitive abilities.

Generally, the movement forms used in the therapy sessions are simple everyday movements initiated by the child and, at times directed by the therapist. As discussed in the work of Kalish-Weiss, the therapists utilize mirroring, physical touch, games, and rhythmic activity to bring about changes in body image. Verbal interpretations are also used "to reinforce the awareness of concrete reality" (p. 66). In addition, music is frequently used, since "its rhythmic and measuring aspects help to structure sessions for clients who are unable to decipher or give meaning to their own body signals" (p. 65).

In an unpublished paper presented at the ADTA Conference (1979), Betty Blau stresses another form of intervention—direct muscular intervention—in her treatment of a three-year-old autistic child named Mel. Reports indicated that Mel was functioning below the 18-month-old level. Blau's goals in working with Mel were "to improve muscle tone, spinal integration, balance, general body image and awareness of the outside world" (p. 2), specifically by establishing eye contact, alleviating head lag, and achieving an upright posture without support. Blau used exercises designed for infants which developed muscle coordination and distance perception, as well as providing initial contact between patient and therapist.

One exercise involved touch, bending, and stretching of the patient's legs to establish body boundaries as well as awareness of another person.

> My body, pushing against Mel's feet, legs and abdomen provided proprioceptive activation. My hands, pushing his knees till they extended and pushed my body away, provided the external stimulation by which the muscle tension could be discharged. (p. 3)

The immediate result of this exercise was spontaneous eye contact. After many months of work, the various exercises corrected his head lag and body posture so that he was finally able to stand without support (bringing himself up from a sitting position), and significantly increased his motor skills.

In summary, the basic and immediate goals for autistic children focus on establishing contact, trust and rapport. Touch is necessary to help define body boundaries and establish connectedness to the therapist and, in turn, the outside world. In addition, dance therapists need to be sensitive and responsive to these childrens' often primitive and caotic communications. Furthermore, since the autistic child generally does not communicate his/her needs, a creative demand is placed on the dance therapist to initiate all avenues of self expression and learning.

Finally, in order to establish contact, the dance therapist must be able to reflect, in the most basic way, the movements, rhythms, and feelings of the autistic child. All of these place tremendous demands on the dance therapist.

Learning Disabled and Language Handicapped

Dance therapy with learning disabled children generally centers on developing the child's perceptual, organizational, and experiential processes. Problems common to these children include distorted or fragmented body images, difficulty with coordination and balance, poor self-concepts, and behavioral and perceptual problems.

Many dance therapists who work with this population prefer to work in small groups, often in a school setting. A structured approach that provides challenge and a motivation to learn is often stressed. According to Puder and Marx,

> In working with children, it is found that the so-called classic Chacian approach in dance therapy is frequently exactly opposite to the needs of many children. Indeed, dance/movement therapy with children is distinctly different from dance/movement therapy with adults. For children, an individual task analytic approach is important. The best approach is one that meets the developmental needs of the child, fostering healthy egos and positive self images. Security increases with firm, consistent structure and boundries (Puder & Marx, 1980, p. 38).

The use of structure and boundaries is emphasized by Marcia Leventhal (1973, 1974, 1979, 1980), psychologist and dance therapist, who has contributed significantly to the practice of dance therapy with this population.[2] Leventhal's work with special children (autistic, emotionally disturbed, developmentally disabled, and learning disabled) spans more than 20 years and encompasses what she refers to as an "integrative treatment model" (1982).

Basic to all of Leventhal's work is her stress on proper movement sequencing and attention to the developmental process. Leventhal finds children progress remarkably when their level of readiness is carefully assessed and the interventions have a developmentally stage-appropriate sequence (1986).

In 1979 Leventhal described her work with a group of children with learning and behavior problems. With the children seated at a table, early movement work focused on the hands and arms in non-threatening warm-ups and simple exploratory gestures including reaching out, taking in toward the self, pushing away, and so on. In this way the children learned control and mastery as well as the experience of choice (acceptance and rejection of desirable and undesirable stimuli). Later, as the children became more able to focus their attention and control themselves in a gradually increasing space, Leventhal introduced fuller body movements.

The concept of movement structures reflected in Leventhal's work demonstrates a viable tool for growth. Within secure boundaries set by the therapist—the form, time, and spatial boundaries of the movement work—each child is recognized as an individual and encouraged to become self-directed. While the therapist may use many intervention techniques, the primary focus of the work is helping children to discover themselves and others through and organized and structured exploration of their movement potential. As the positive self concept is enhanced through mastery and discovery, children become more able to live fully in the environment, inspired by a new motivation to learn. This, in turn, inspires growth and confidence in the areas of socialization and communication.

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[2] Leventhal edited the book *Movement and Growth: Dance Therapy for the Special Child* (1980). Several of the articles reviewed in this chapter are from this source.

Many of the same goals are stressed by Puder and Marx (1980), whose work aims " . . . to create an atmosphere in which the children feel a sense of belonging and group support, a sense of competency and ability to succeed, and a sense of worthiness . . ." (p. 41).

A typical group session conducted by Puder and Marx begins with warm-up yoga exercises, with the children on mats in a circle. The focus is on developing group cohesiveness and having each child center his/her energy. Work is then done in balance, gross motor skills, strength, socialization skills, and strengthening body image. This is followed by using the body to shape letters and patterns, by work in visual and auditory sequencing and memory, and then by creative exploration. Each session ends with relaxation techniques.

Puder and Marx stress that it is not always possible to determine the etiology of learning disabilities, even after all psychological and educational information is reviewed and educational and developmental tests are evaluated. The therapist, therefore, should be flexible in the use of methods and techniques.

Elizabeth Polk (1974), a pioneer in her work with children, stresses the need to develop a sense of belonging and group spirit. It is important to provide the group with challenges that do not result in competition among the children. Such challenges include playing in a rhythm band, marching in formation, forming a pyramid, group dancing, group games, role playing and dance-acting. The creation of a happy group atmosphere is essential for the success of these group activities. "If laughter, music, and movement work together," Polk states, "the joy becomes contagious" (p. 58).

Polk's group sessions, like those of Leventhal and Puder and Marx, are structured. Each child is assigned his/her own special place in the room. This provides a feeling of security and teaches the child to respect the personal space of others. It also helps develop spatial orientation and directionality.

Polk often begins group sessions with music (e.g., rhythm instruments, records) in order to develop skills in listening and responding. These, says Polk, are "prerequisites for any kind of communication" (1974, p. 57). Drums, punching bags, balloons, and/or beachballs provide the children with an outlet for aggression and frustration. Balloons are also effective in developing visual perception and body image, as the children use different parts of their bodies to toss the balloons. Various other props including hoops, puppets, and jump ropes are also used. The use of props is always accompanied by music. This creates "a sense of joy and freedom of movement" (1974, p. 58), and leads to more complex movements such as stretching, lifting, twisting and dancing. The development of coordination and rhythm is also facilitated through the use of props.

In summary, those who work with learning disabled children emphasize using body movement in a structured and organized fashion as a tool for conceptual learning and body image development. The dance therapist's active participation, verbal and non-verbal, as a structuring agent and educational guide, are paramount.

Language handicapped children are another special child population that can benefit from dance therapy. According to Salus and Schenberg (1971), body movement work with these children can open avenues for expression, promote the learning of essential self-concepts, teach space orientation, and provide creative outlets for personality growth.

Salus and Schenberg worked with a group of nine children with a wide variety of speech defects. These children also suffered from a low level of auditory memory, organic brain damage, severe emotional deprivation, and were hard of hearing. All had some speech. Since some of these problems overlap with those of emotionally disturbed and learning disabled children, the approach used is similar to that used by many of the dance therapists discussed in this chapter. Another similarity is that sessions were conducted in a school setting.

The dance therapy sessions began with exercises such as stretching and jumping, done in time to drum rhythms or music. Learning, according to Salus and Schenberg, is acquired by repetition of movements which eventually leads to mastery. Discussion of body parts and creative activities were also stressed. The latter, including creative movements and dance, mimicry, pantomime, improvisation, and drama, would often be related to classroom studies. For example, if the children were learning about farms in dance therapy sessions they would pretend to be farm animals. In general, however, the methods used depended on the children's needs, developmental stages, interests, and former experiences.

Norma Canner's (1972) work with nonspeaking hospitalized children focused more specifically on utilizing movement and rhythm to promote language development. The participants in the program were six adults (teachers) and six children, most of whom could hear but not speak.

During the morning therapy sessions, the teachers and children would form a circle, all holding onto an elastic, and sway and sing in rhythmic movements. Later, the children were helped to become more comfortable with their bodies through games using mirrors, touch, and naming body parts. They would also explore various sounds: vowels and consonants; blowing; hissing (hands put on lips to feel); buzzing (feeling air and vibration); humming; clicking (using mirror to watch action and placement of tongue). Work was also done in combining speech sounds, making syllables, and improvising sounds. More creative movement was performed in the afternoon sessions, including dance, improvisation, and playing instruments while moving and vocalizing.

Each child worked with one teacher within the group structure. At first, one teacher was assigned a particular student, but later the teachers moved around and changed partners. As good relationships developed, more and more spontaneous movement and group interaction occurred.

As a result of this program, some of the children realized for the first time that their faces and bodies had separate parts, each with their own function. In addition, the more withdrawn children began to interact with others.

School Phobic Children and Breathing Problems

Dance therapy has also been used to treat breathing problems in school phobic children. Breathing problems often reflect underlying emotional conflict surrounding issues of ambivalence toward a loved object upon which the individual is dependent. This has been a focus of Elaine Siegel's (1973a) work with disturbed children. She found that children diagnosed as "school phobic" often had respiratory problems in the form of shallowness of breath. The following case of Debby demonstrates one child's problems concerning school, separation-individuation, body image, and symptomatic shallowness of breath.

Although Debby appeared negative at first and skeptical of Siegel, Siegel nonetheless initiated breathing work with her, which she described as follows:

> We breathed in time to slow adagios and discovered that one's whole body wants to bend with the music; we breathed quickly to Chopin's waltzes and found ourselves skipping, while Miriam Makeba's African ullulations made us feel both angry and sad. (p. 335)

In responding to this new experience, Debby at first expressed feelings of having been "sneaked up on" (p. 336), with the result that Siegel now knew how Debby felt about 'everything'. Siegel's analysis of what had occurred however, differed from Debby's. Debby

> . . . had allowed rhythmic patterns from the outside to be superimposed on her own, shallow, scared intake pattern, and by submitting to them had experienced a return of spontaneity as well as of some of the affect she had been so busily blocking out. All this felt quite alien to her ego, and so she had to invest me with magic omnipotence instead of admitting to her own strength. By giving me all the power, she also handed me the controls over her hostilities and could now blame *me* if she didn't go to school. . . . (p. 336)

The next important step was to help Debby to understand her feelings, and build a stronger and more realistic sense of her physical self. In this way, she could better cope with the surfacing ambivalence toward her mother, without fear that this ambivalence would destroy her (Debby) or her relationship with her mother. Now that Debby had transferred her ambivalence feelings to Siegel, Siegel could help her to work them through. With Siegel's guidance, she began to explore new aspects of herself through dance movement. (p. 337) "Debby discovered herself to be strong when doing push-ups, agile in climbing a ladder, and graceful in beginning ballet exercises." (p. 337)

Siegel contends that experiencing the reality of one's body as a separate entity in space, through independent dance action, encourages the ego functions of reality-testing and problem solving, and in turn facilitates in the separation-individuation process. Through discussions of feelings which surfaced while doing these and other exercises, and through Siegels' tentative interpretations of Debby's movement experiences, patient and therapist were able to explore and understand together Debby's conflicting and frightening emotions. This, in addition to Debby's new found strengths, provided her with the confidence she needed to go to school and to begin separating from her mother. Finally, through the transference relationship she established with Siegel, she began to explore her emotions in the safety of the therapeutic situation.

General

Jane Downes (1980) describes her use of a humanist approach to dance therapy for special children (no specific diagnosis is given). Downes sees freedom of expression as a basic tool for the healthy development of full selfhood. The goals of her treatment model are to enable the children to become aware of their own resources, to perceive themselves as worthy beings, to communicate ideas and emotions, and to experience their own senses as an active force in their lives.

In Downes' work, movement forms are chosen by the client from the repertoire of everyday actions, and from the actions inspired by creative imagery as directed by the therapist.

> By using her body movement as the structure . . . the movement therapist supports, enhances, mirrors, absorbs, and otherwise participates in the meaningful movement expressed by the . . . child. The movement therapist becomes the catalyst for change . . . [by] afford [ing] the child the opportunity to move through the external environment as well as his internal one in a purposeful, exciting and achieving manner. Much of this is spontaneous. (p. 17)

Specific problems such as self-concept, body image, peer relationships or the inability to relate to an adult in a meaningful way may be addressed by the dance therapist in the process of the child's movement explorations.

Downes believes that the use of movement dynamics explored systematically enables the dance therapist to foster a full range of communicative expression in the special child. The child's selfhood emerges as inner drives and states of being are made manifest through expressive movement activities. The themes and issues which emerge are regarded empathicly by the therapist. The therapist becomes a model of functional adaptive behavior for the child, who is still in the process of learning how to use his/her own internal regulating devices. Ultimately, for the young client, "individuality and identity will emerge from deep levels of the self" (p. 17).

Summary

The preceding review of the literature concerning the special child reveals the use of a broad spectrum of dance therapy techniques. One area which illustrates this spectrum is in the way dance therapists view their work from a theoretical perspective. At one end of the spectrum are those dance therapists who emphasize seeing the parameters of body movement as a complete theoretical framework having meaning in and of itself and which is intimately interconnected with the growth process. These practitioners support this view by utilizing terminology which describes and reflects behavior in movement terms with little recourse to formal psychological terminology. At the other end of the spectrum are those dance therapists who find it more meaningful to interface psychological concepts, mainly from schools of thought such as psychoanalysis, ego psychology, or the developmental and cognitive schools.

Related to this range of theoretical perspectives is a range of views concerning the dance therapist's "use of self" as the agent of change. In this area, the spectrum ranges from teacher to psychotherapist, with many dance therapists falling somewhere between or straddling both.

Dance therapists working with the special child also espouse a broad range of goals. This range includes the use of dance therapy for: making emotional contact with removed and/or autistic children; building the body image of the child; facilitating cognitive aspects of development; developing self-control and physical mastery as well as meaningful self-expression; and facilitating social interaction.

The different views regarding theory, practice, and goals provide a wide range of possibilities within which dance therapists appear to move around fairly freely. While they may have particular preferences, all express a special concern for stretching oneself to meet the unique needs of the children with whom they work. Most seem, at one time or another, to draw from the complete range or potential inherent in the medium of body movement and dance.

Dance therapist William Freeman is currently spearheading a movement to encorporate dance therapy into special education programs in the public schools. Freeman was successful in his efforts toward this goal in the state of Kansas, and is now working for national acceptance of dance therapy as an important special education tool. A similar movement in New York is developing under the guidance of Tina Erfer. Erfer is the originator and facilitator of an ongoing professional peer training and support group for dance therapists working the special child in educational settings.

19

Dance Therapy for the Mentally Retarded

Generally speaking, dance therapists working with the mentally retarded tend to work with the more severely retarded patients individually, and with less severely retarded patients in group settings. The focus, like that of dance therapy with the special child, is generally on improving body image, coordination and motor skills, promoting socialization and communication, and developing the individual's confidence and awareness through mastery and self-expression. All of these lead to increased intellectual capacity and growth.

The use of repetition is especially helpful for this population. Liljan Espenak (1975), one of the six major dance therapy pioneers, stresses repetition through the use of rhythmic exercises and music. The rhythmic beat, facilitated by music, provides a structure which helps to organize movement and thinking, and leads to mastery of functional and recreational skills. These are important in fostering ego development, which, Espenak believes, is hampered in retarded individuals because of the negative responses directed towards them from other segments of the population.

Espenak summarizes her approach, called Psychomotor Therapy, with this population:

> The . . . value of . . . dance activity . . . lies partly in the stimulating quality of rhythmic movement and activity, but partly also in the structuring properties of physical education. . . . Psychomotor therapy's efforts for reaching and effectively changing the undeveloped self-image of the retarded has been of great help in removing some of their social barriers, and in overcoming their fear of interpersonal contact by offering them a tool for communication and a physical-emotional program to help them grow as personalities. (pp. 3–4)

Susan Moss and Stephen Anolik (1984) also emphasize the value of repetition in working with the mentally retarded. They believe that any clear structure of exercises, repeated for many weeks, builds body awareness in the retarded, and could be used to achieve other dance therapy goals with this population. They caution against the tendency to avoid teaching physical techniques which seem to be too complicated for retarded patients. In this connection, Moss and Anolik conducted a study to ascertain whether retarded patients could be taught relaxation techniques, and if learned, whether the relaxation response could be used to calm them when emotionally upset.

They taught Jacobson's (1929) progressive relaxation technique to five moderate to severely retarded adults, in a group setting three times per week (6 sessions). Pre- and post-testing of skin temperature of the index finger were administered as physiological indicator that the relaxation response had occurred. (Skin temperature rises in the hands and fingers when the muscles relax.)

The authors found that the five clients of the pilot study were able to learn the relaxation response. The skin temperature tests of three of the patients showed significant differences between pre- and post-test; although the differences in the other two clients were not statistically significant, their mean temperatures did rise.

The authors attribute their success in teaching the technique to a high staff-to-patient ratio (2–5), and to repeated use of verbal and physical prompting during sessions. The verbal prompting focused on key words, such as "calm" and "feeling good." The physical prompting consisted of touching the body part to be tensed and relaxed. As the work progressed, fewer prompts (particularly physical prompts) were needed, indicating the patients were increasing their body awareness. In addition, they seemed to associate the room, the therapists, and the skin temperature testing machine with the relaxation technique. Contrary to the authors' initial concern about the effects of using the biofeedback equipment, the patients became progressively calmer when they entered the room, immediately, and eagerly raising their finger for the skin temperature test.

As a follow-up project, two classroom teachers were trained in the relaxation technique. One used it on a regularly scheduled basis, three times per week. The other used it more informally when she felt her class was becoming restless. The first teacher got a positive response using the technique during crises; the second did not. Thus it appears that "frequency of exposure and concentrated clinical attention are important factors in the client's ability to generalize the benefits of relaxation training" (p. 55) and perhaps other forms of body movement training as well.

Because language may be poorly developed in mentally retarded patients, some dance therapists have concentrated on its development. The decision for emphasizing language development may rest on the extent of the client's retardation. With more severely retarded individuals, the focus is likely to be on developing remedial language skills, often as part of intensive one-on-one therapy. The less severely retarded, such as the trainable or educable patients, may already have developed basic language skills. Dance therapists who work with these patients, usually in group sessions, often stress further language development by encouraging conceptualization and verbal expression. This helps the patients organize their thinking and improve their communication with others.

Promoting verbal expression was one of the goals of a dance therapy program described and filmed by Weiner, Jungels, and Jungels (1973). The dance therapy was part of a creative art therapy program which also included art, music, and drama therapy. It was held at a New York public school during 1970–71 for a small group of educable mentally retarded children. Its purpose was to determine whether ease and mastery in the creative arts would help improve the children's overall functioning in language, body image, and coordination.

The dance therapy sessions included spatial exercises to "alter body-image disturbances, improve understanding of directionality, laterality and improve balance coordination" (p. 46). The authors stated that "no particular technique, style or steps were taught" (p. 46). Work was also done with fantasy, interaction, and group and individual improvisations. Verbal reinforcement, music, and various props were also used. By the end of the program, according to the authors, the children displayed increased self-confidence and greater control over their bodies, and their movements were more aggressive and spontaneous.

Maureen Costonis' (1974) work with a severely retarded 9-year-old with secondary emotional and behavioral problems concentrated on language development and on shaping the boy's self-destructive behaviors into expressive movement. She focused on developing the child's body image and body/environment awareness, using techniques which included mirroring his ideosyncratic mannerisms and free-flowing dance. Costonis believes that ". . . a client who engages in stereotyped gestures can transform them into dance movement and substantially expand his movement repertoire . . ." within a short period of time (p. 151). Costonis utilized her own notation system—the Movement Range Sampler (MRS)—to describe small changes in the boy's movement during the dance therapy sessions.

As a result of the dance therapy, the child's ritualistic behaviors decreased and ordinary behaviors (e.g., walking, running) became more normal. Also, the patient spoke more frequently during the dance therapy sessions. This increased frequency in language was attributed to the increased physical contact between therapist and patient.

Replacing a retarded child's bizarre mannerisms with more appropriate social behaviors was also the focus of Elaine Siegel's (1972) work. By encouraging free expression and the uninhibited acting out of fantasies, Siegel facilitated the intellectual and emotional development of a 10-year-old retarded boy. The therapy sessions consisted of warm-up exercises, other physical exercises, games (rhymes, body image games), dance (polkas, made-up dances), specific movements (hops, jumps), spontaneous and fantasy movement, and play-acting. In accordance with psychology theory, Siegel believed that the child's "bizarre behavior was not caused by his retardation but by an anal fixation the reduction of which allowed for further growth" (p. 107). That is, by providing an outlet for the controlled acting out of the child's innermost fantasies, Siegel helped alleviate much of his anally compulsive behavior. Also, during the period of the therapy sessions, the child's IQ increased from 40 to 70, his social behavior improved, and psychological tests revealed fewer emotional problems.

Summary

As with other populations, five major goals emerge for mentally retarded patients: cognition (which includes body image); physical and emotional mastery; self-expression; self-confidence; and socialization. However, with this population, there is less concern with transference phenomena and more stress on social participation, communication, and interaction skills. The technique of repetition as a tool for refining and crystallizing new areas of growth and psychophysical education is also emphasized.

20

Dance Therapy for the Physically Handicapped

The physically handicapped population includes individuals with one dysfunctional problem as well as those having multiple handicaps. Regardless of which group the dance therapist deals with, the therapist's goal, as portrayed by the articles reviewed here, is to increase the patient's self-awareness (and with it, awareness of others and of relationships); to promote a sense of self-confidence and well-being; and to increase the individual's perception and range of movement.

Blind and Visually Impaired

Blind or visually impaired individuals often have tentative and restricted movement styles caused by fear of moving without sight. Joanne Weisbrod (1974) stresses the importance of having a safe place to work. A secure environment promotes a more complete use of the body, and an atmosphere where more open and honest communication can take place. The therapist must pay careful attention to the patient's movements to insure safety and to help him/her dissipate anxiety. Allowing sufficient time for patients to become familiar with studio space is essential. Feeling secure in the working space facilitates the exploration of aggressive movement and space. Once the individual becomes secure in the space, he/she will feel freer to increase the range, scope, and depth of psychomotor expression.

Weisbrod's overall goal is to provide the visually impaired with the means to "fully own, use, and gain pleasure from their bodies" (p. 50). Sessions are designed to provide this by increasing the participants' awareness of their movement strengths, weaknesses, and potential, improving their body image and gross motor coordinations, reinforcing the positive aspects of their existing movement styles, and increasing their range of responses and scope of movement. Activities include working with movement dynamics, energy flow, momentum, rhythm, space, multisensory experiences, relationship awareness, and role-playing. Weisbrod emphasizes the need for auditory cues, and uses musical instruments, clapping, fingersnapping, recorded music, and vocal instructions.

Martin (1974) writes of the blind person's inability to imitate the movement and to respond to the movement of others, as well as of the fear that impedes movement and results in poorly developed motor skills. Her main intervention style is the teaching of a wide variety of creative movements (not dance) which, she believes, can eventually help the blind individual to "participate in a larger share of life and come to move with more confidence, freedom, and dignity" (p. 62).

Martin believes it is important for the therapist to move with, narrate, and reflect the patients' feelings by picking up on their actions and moods. She uses leaders to initiate exercise within the group. Though she sometimes suggests movement verbally, no orders are given, and she makes it a point to use everyone's name during the sessions so each one feels special. Like Weisbrod, Martin also uses music.

For both Weisbrod and Martin the goal is the same: to help the blind and visually impaired increase their self-awareness and scope of expressive movement as a means of building self-confidence and the capacity for more meaningful relationships with others. As Canner (1980) points out, this is in marked contrast to the approach of past years which saw as its goal teaching blind people those movement and behavior patterns which would make them more accepted by the sighted world.

Individuals who are blinded later in life through accident or illness often experience emotional problems stemming from a sense of loss and sudden dependence on others. Mary Frost (1984) describes her work with just such an individual, Richard, a 56-year-old man whose refusal to cope with his sudden blindness two years earlier had led him to become obsessed with "calendar counting" (i.e., figuring out what day of the week a given day would have been x number of years ago).

The treatment was conducted in a partial hospitalization program two days a week for six hours each day. Clients participated in milieu and recreational therapy and received instruction in daily living skills. The object of the study, Richard was the only blind person in this program. Twice a week he participated in two hours of expressive therapy which included 30–40 minutes of moving to music led by a dance therapist, followed by an hour of verbal psychotherapy which was co-led by the dance therapist and an art therapist. In three of the 26 sessions, art therapy was used to help Richard express feelings brought up by the dance therapy.

Frost's goal was to explore the relationship between the changes that occurred in Richard's movement repertoire and the changes that occurred in his psychological functioning during the course of the therapy. Frost described these changes from her clinical observations, then analyzed and charted them.

Richard's treatment goals were to reduce obsessive behavior (calendar counting) and, ultimately, to help Richard confront his situation and enter a school for the blind. The author used dance therapy to support these goals through focusing on his feelings, improving physical mobility, and increasing social contact. In addition, verbal and nonverbal contexts were used to unearth the emotional conflicts which were fueling the calendar counting ritual.

The treatment assumed two stages. Initially, Frost worked to help Richard "shift from movements restricted and close to his body center to movements that flow from the center to the periphery." (p. 29) This expanding use of space and ease of movement began to break the grip of his obsession. In his first dance therapy session, Richard walked in a bent over posture with arms extended in front of him for protection, and feet spread apart for stability. In the fourth dance therapy session he learned to orient himself, using the sound of the therapist's hands clapping as "radar." After the sixth session (about three weeks in treatment), he could navigate by himself in the two rooms of the day hospital program. Later he took on the outside world, using a cane to walk down the street to visit a friend.

Interestingly, as soon as Richard began to make social contact with other group members, the link between his obsessive behavior and his loneliness became apparent; he did not calendar count on the days he attended the program. In addition, Richard's range of emotional expressions increased with his mobility. In the second stage of treatment, the dance therapist gave Richard ample opportunity to use symbolic movement to externalize his inner state. Over a period of weeks, Richard's psychomotor expressivity increased significantly. He began reaching into the center of the circle for, in his words "good health"—when hopeful, or "for nothing"—when despairing. He began trying to push away and symbolically throw off what he called, "his crazy head."

In session thirteen, he clapped his hands stiffly, and pushed himself back strongly with his arms, stating that he was trying to push away what he believed to be "evil" (interpretation—his blindness). In sessions fourteen through sixteen, these emotions climaxed as Richard accepted that his primary problem was blindness and expressed the intense anger he had felt at the restrictions and dependency this had imposed in his life. Using expressive symbolic movement he angrily flicked with his hands and arms, pushed away, and threw things down. In art, he drew a road with himself at the end of it, signifying that there was no hope. Outside the sessions, his calendar counting temporarily increased in intensity but could no longer cover his anger.

At this point, Richard used the verbal sessions to connect his angry feelings with frustrating events from his past: low paying jobs, social isolation, dependency on his family. His frustration and despair gave way to determination, as in movement session twenty, he "punched forward on the diagonal and stomped his feet into the floor" while declaring that he was "burying calendar counting" and "was going to have a new life."

In session twenty-five, Richard's last in the program (before going to a school for the blind), he enjoyed the support and strength of the group as all moved together in percussive stamping, arms interlocked around the circle. Richard received warm good-byes and good wishes, and appeared on the verge of tears.

After one month at the school, Richard's calendar counting had totally stopped. One and a half years later Richard had made friends, learned enough Braille to deal with everyday tasks, and could maneuver around the city. He married, was helping to raise his thirteen old stepdaughter, and worked 25–40 hours a week at the school.

Frost found an inverse relationship between the intensity of Richard's obsessive behavior (the calendar counting) and the "expansiveness" of his movement ("locomotion into space") (p. 28). In general, the more mobile Richard became, the less he calendar counted. Frost believes that more studies should be performed, correlating clients' emotional progress with movement changes, to statistically verify the patterns she observed in this case.

Deaf and Hearing Impaired

Peter Wisher (1974), a dance educator, is one of the few individuals to write about his work with the deaf and hearing impaired. He stresses that the dance experience (as in the case of blind people) reduces feelings of isolation and motivates social relationships and group feelings. This is particularly important for deaf and blind individuals, who frequently grow to be rigid in behavior and lacking in social consciousness. Wisher stresses group work for this reason, and creates sequences which promote feelings of solidarity.

Because physical education is often unavailable to the deaf, they may lack neuromuscular skills. This is due to social deprivation, not to inherent physical weakness. Dance movement in conjunction with physical education can easily relieve deaf people of the stigma of appearing muscularly handicapped. Wisher also feels that deaf people are well-oriented toward movement, since sign language, the "language of the deaf;" is communication based upon expressive gesture. He believes in total communication with his deaf students: a combination of signs and movement, manual alphabet, speech and lip reading. Through his methods, Wisher's students have experienced feelings of self-worth and confidence they previously lacked. These feelings come from within, and extend toward others, both hearing and non-hearing.

Wisher's work with a group of deaf and some non-speaking college students at Gallaudet College in Washington, D.C. was the subject of a CBS News segment in early 1987. Wisher described the students' training in dance improvisation based on exaggeration (i.e., expanding and broadening) of sign language symbols into abstract dance form. Because signing is essentially expressive nonverbal communication through body movement, Wisher believes that the hearing impaired have already highly developed the art of communicating emotions nonverbally.

While Wisher's work is not formally considered dance therapy, it is extremely therapeutic and could easily become psychotherapy; the joy, skill, and expressivity displayed by these students as they danced in the CBS News segment were obvious. Wisher's work confirms that for deaf individuals, dance can be a major avenue for building movement skills, communication, self-expression, confidence, and a feeling of community and belonging in the world.

Physically Handicapped

Both Norma Canner (1980) and Diane Duggan (1980) have written about their work with physically handicapped children. Each stresses the importance of body contact and developing kinesthetic awareness, and each recognizes the link between a child's physical development and his/her cognitive and emotional development.

> Our body is the basic learning tool at birth. Tactile stimulation informs and nourishes the infant. His body serves as a reference point for organizing the impressions which he receives from his outer and inner world. (Canner, 1980. p. 54)
>
> The establishment of a complete and integrated body image is of major importance with these children, both because of its importance in cognitive development and in the acquisition of self-help skills and because of the extent to which it is lacking. The body image is based primarily on kinesthetic and tactile input. (Duggan, 1980, p. 49)

Canner worked at a school for the blind with children who, in addition to being blind, had other physical and/or emotional difficulties. She used simple everyday movements to help the children increase body awareness, reduce anxiety, and develop locomotor skills.

When working with the physically handicapped, Canner streses tactile stimulation of body parts and experiencing dynamic contrasts (e.g., open-closed). In addition, she encourages movements that are both active (moving) and passive (being moved by others).

Canner often uses clay and tin foil when working with her children. By pounding, pushing, and throwing the clay, the child realizes a range of kinesthetic expression. The foil is used to create stick figures, which leads to partner work. After exploring one another's shapes, the group creates sculptures of the clay and foil in the shape of themselves and their partners. "The aim of this process is to reinforce and awaken their own body awareness and also help them to become sensitive to the shape of another person" (p. 54).

Duggan, who works with severely handicapped children, stresses the same basic goals: developing motor skills, body awareness, and a means of expression and communication. Because of the severe physical limitations of the children she works with, she also emphasizes the need to provide motivation to move against the "combined factors of cerebral palsy, side effects of seizure medications, chronic illness, and general apathy which make even the simplest movements difficult" (p. 50).

The presence of other adults in the group is also sometimes required. In extremely low functioning groups, it may be necessary to have an adult holding each child (no more than six children per group). If this is not possible, they may be positioned, using pillows for support, so the children can all see and touch one another. Like Canner, Duggan often uses props, as it is easier to get the children to focus on one another when they have toys or props which can be passed among them.

While Duggan and Canner, in the articles reviewed here, wrote about group work with physically handicapped children, dance therapists also work with this population in individual sessions. Billie Pivnick (1984) described her one and a half years of dance therapy treatment with Peter, an 11-year-old boy with congenital cerebral palsy.

Peter was referred to dance therapy by his orthopedic surgeon and physical therapist for relaxation training. They hoped his muscle contractions could be reduced in order to avoid surgery for an approaching growth spurt. Other methods had failed, due to Peter's oppositional behavior and short attention span. In addition, Peter's mother had recently returned to work, so could no longer perform his range of motion exercises with him at home.

When dance therapy began, Peter exhibited the following physical behaviors. His movements were primarily strong, quick, direct, and bound. His posture was flexed at the hips. Some muscles were rigid; others were weak. He had problems coordinating his movements, particularly in the lower extremities. This, combined with muscular spacticity, gave a fragmented impression and a jerky, hopping, quality to his gait. His balance was poor, his right leg dragged, and his walking was dependent on devices. Tight thorasic muscles constricted his breathing.

His mental status included clear, organized thinking; creativity but stubbornness in the face of others' demands; manic affect; some compulsive behavior; aggitation; high distractibility; and low frustration tolerance. He appeared friendly and extroverted with a quick wit and well developed social, bantering style.

Goals of treatment fell in two general categories. The physical goals included improving gait and loosening muscle tension to avoid surgery. The emotional goals were eliminating oppositional behavior and distractibility which were interfering with the physical therapy, and resolving the developmental conflicts to allow age-appropriate maturity and integration to occur.

Dance therapy began on the physical level, with the dance therapist teaching abdominal breathing to bypass the tense thorasic area. Breathing and relaxation were then combined with stretching, in exercises performed first with the help of the therapist, then by the patient alone in the sessions, and then at home. Peter discovered by himself that using the relaxation techniques while walking improved his control. This, as with each success, improved his self-esteem.

In the second stage of treatment, Peter recognized the emotions present in his actions. He created his own form of foot hockey with a rubber ball, which vented his aggressive feelings. He symbolically protected his personal boundaries by physically pushing away, using expressive movement, and allowed himself to be videotaped. Though anxious and shy at first, he realized that being videotaped made him feel like a celebrity, giving him a sense of pride in himself and his accomplishment. He began to talk in the sessions about emotional conflicts at school and at home, and recognized the connection between his angry feelings and his "inadvertent" kicks at his classmates and mother.

In the third stage of treatment, Pivnick concentrated on improving ambulation. By altering his gait pattern, Peter was able to stop dragging his right foot and mastered the "Four Point Gait" (with crutches) which his doctors had given up on previously. He learned on his own to climb and descend stairs, and began taking long walks in his neighborhood and over the rough terrain of the hospital grounds. His mastery of these tasks elated him and continued to improve his self-esteem.

The fourth stage of treatment continued to develop Peter's autonomy, physically and mentally. He found his own way to the dance therapy room for sessions and kept increasing his walking distance. He continued to express his emotions verbally, even confronting his bus driver about habitual tardiness! With Pivnick's help, Peter developed methods to defend himself against dogs in his neighborhood, and learned modified Tai Chi exercises from an orderly in the hospital.

In the one and a half years of treatment, the referral goals of improved self-management and self-esteem, decreased oppositional behavior, and surgery avoidance were accomplished.

Summary

The diversity of the physically handicapped population as a whole has led each therapist to establish methods and parameters geared specifically to the group with which he or she works. Regardless of the scope available to each group, the goals of therapy usually encompass decreasing fear, anxiety, isolation, and limitations, and to promote self-confidence, well-being, mastery, pleasure, autonomy, and the ability to relate to others as well as understanding and expressing oneself. And finally, a special problem facing this group—which the dance therapist must also confront—is helping the individual to face his/her disability and, perhaps hardest of all, accepting the patient's distress over their situation.

21

Dance Therapy for The Elderly

Dance therapy with the elderly began as early as 1942, when Marian Chace used her dance therapy techniques with older patients (H. Chaiklin, 1975). However, it was not until the last two decades that dance therapists have turned their attention to the unique needs of these individuals, whose numbers have been growing in recent years.

Problems common to most of the elderly—those who live in the community as well as those who are institutionalized—revolved around physical limitations, dependency on others, social isolation, loneliness, loss of self-esteem, death of peers, and fear of death. As Stark (Samuels, 1973) points out, despite these new forms of stress brought on by aging, the elderly have few available tension-relieving outlets. Dance therapy can provide such an outlet.

In accordance with the problems outlined above, the goals of dance therapy with the elderly generally focus on three major areas: social, physical, and psychological. The social aspect emphasizes social interaction, sharing, and support. The physical aspect attends to the aging individual's need for physical exercise and expression. Promoting personal integration, the expression of emotions, and feelings of self-worth and well-being are the general goals in the psychological area.

Most dance therapists who work with the elderly work in a group setting. The group provides a safe and supportive atmosphere that fosters communication and sharing.

Significant benefits are also derived from the effects of physical contact, especially touching. Sandel (1980) points out that "touching and being touched appear to have a rejuvenating effect on the participants which increases their alertness and responsiveness to others" (p. 2). In particular, physical contact helps to alleviate fears of loneliness and isolation and to ally the sensory deprivation which frequently befalls the elderly.

Some dance therapists stress the physical aspect of dance therapy with this population, believing that benefits in this area will give rise to parallel benefits on the social and psychological levels. This somatic approach is exemplified by the work of Irwin (1971) and Garnet (1974). Each describes the use of physical exercises to maintain and/or improve muscle tone, posture, flexibility, joint mobility, and movement range. Relaxation techniques to release psychophysical tensions are also emphasized. These include calisthenics, Jacobsen's progressive relaxation (used by Garnet), and techniques of yoga (used by Irwin). The re-establishment of coordination, spatial orientation, kinesthetic awareness and control are other physical goals.

Despite the physical limitations of many aging individuals, a wide range of movement sequences can be utilized. For example, Garnet uses swings, falls, suspensions, twists, stretches, bends, and pushes and pulls, done in all directions. She finds that participants tend to discover the limitations of their own movement potential and do not go beyond them. Irwin notes that the "methods and techniques are innumerable, limited only by the training, experience and, above all, the imagination of the therapist" (1972, p. 169). She recommends that dance therapists who work with the elderly have strong medical backgrounds.

Although this approach focuses on physical goals, attention is also given to the social and psychological areas as well. Because the elderly are often restricted in their range of mobility, participating in even simple movement work can give them a sense of achievement, vitality, and self-esteem. Pleasurable and recreational movement experiences, performed in a safe and non-demanding atmosphere, provide additional social and psychological benefits. Furthermore, memories of youthful feelings and carefree experience are often evoked by movement. Garnet calls this "muscle memory," a concept she derived from Hebb's (1966) "reverberating circuits of association."

The use of memory and past experiences, that is, reminiscence, can be a powerful tool in working with this population. Reminiscing may involve sharing memories of youthful experiences, or acting out activities such as shopping, going out, or working on a job or at a home. The associations triggered by these memories and activities often work to give the person a stronger association with the present.

While those dance therapists who use a somatic approach often incorporate reminiscence into their work, other dance therapists use this technique as the basis of their approach. For these dance therapists, the social and psychological goals take precedence over the physical goals.

Sandel (1978b) conducted a study specifically on the use of reminiscence with the elderly. The study took place at a specialized center for long-term elderly patients, and was conducted with five female residents, ages 78–98. The focus of her work was on the use of imagery and reminiscence, with the aim of fostering sharing among group members, increasing personal integration, and releasing emotions, both positive and negative.

Based on the Chacian method, Sandel began sessions with a warm-up using music and structured exercise, and elicited imagery by asking about the movement. She then guided the group through a progression from the sensory experience to a symbolic one and finally a verbal one, allowing a spontaneous unfolding or developing of thematic material. The atmosphere of sharing and support facilitated the expression of even the most painful, negative memories, which became less threatening and hurtful after being expressed.

Sandel's findings support the use of reminiscence as an effective means of achieving psychological and social goals.

In addition to the three major goals of dance therapy with the elderly, Fersh (1980) cites two other goals: cognitive and spiritual. The cognitive goal, Fersh notes, is to stimulate mental functioning and improve the patient's thinking ability. It can be achieved primarily through movement themes and improvisation. Sandel (1978a) may also have been referring to the cognitive area when she stated: "When people participate in movements that remind them of former competencies or pleasures, they often appear more alert, organized, and competent" (p. 740).

The spiritual goal, according to Fersh, is to provide the possibility for a transcendent experience, which "offers the elderly the opportunity to connect with the ongoing energy force which supports the . . . continuity of life" (p. 36). This can help a patient deal with the fear of death. The focus here is on the individual's inner resources.

There is presently only one book, by Caplow-Lindner, Harpaz, and Samberg (1979), devoted exclusively to dance therapy with the elderly. It presents a comprehensive discussion of the sociological aspects of aging (especially in the United States), and the characteristics and special concerns of the elderly. It describes how to establish a geriatric dance/movement program and gives a complete overview of a dance therapy session, including physical, expressive, and creative activities. It also provides a list of musical accompaniment and equipment resources and includes a section on program evaluation.

The following quote from this resource summarizes the goals of dance therapy with this population:

> Therapeutic movement sessions are ideally offered to discover, prevent, arrest and reverse the damaging effects of aging. Opportunities to express emotions, both positive and negative, and to release tensions through movement experiences are invaluable parts of the therapeutic session. The movement therapist also offers stimulation for constructive recall, reality contacts, and social interaction. We are working to promote a freer relationship between body and mind by encouraging affirmative and meaningful gestures and movement. (p. 38).

In short, dance therapy is an ideal medium in which elderly individuals can learn to cope with the unique problems and stresses of old age. It enables them, ". . . in the company of peers, [to experience] the sense of renewal, relaxation and purpose that comes from feeling one's body in motion, in harmony with others" (ADTA, n.d., p. 4).

22

New Dimensions in Dance Therapy

In the last decade dance therapists have been branching out into many new areas, expanding the use of dance therapy to include new populations. The literature on these specialized areas of dance therapy, however, is still rather sparse. As a result, this chapter cannot be considered a comprehensive review, but is rather meant as an introductory look at the work being done in some of these new areas by leaders in the field. These include dance therapy with families, with traumatic brain injury patients, with sexually abused children, and with individuals suffering from eating disorders.

Dance Therapy With Families

Dance therapy with families is relatively new, having emerged primarily in the 1970's, though a few dance therapists had some previous involvement with this patient group. In the 1960's, Bartenieff, Davis, Schmais, and White were involved in analyzing the nonverbal communications observed in verbal family therapy sessions at Bronx State Hospital. Also at this time, Kestenberg was developing her correlations of psychoanalytic thought with effort/shape theory and applying this to her analyses of family interactions, specifically, of mother/child and mother/infant interactions. However, it was not until the 1970's that dance therapists began seriously discussing the possibility of using their observational and dance/movement skills as tools for intervention for family systems.

Diane Dulicai (1976) emphasizes the role of nonverbal communication in family interactions, referring to the work of Birdwhistell, Scheflin, Kestenberg, Davis, North, and Hall. She also stresses the importance of considering "the family from which the patient comes, its culture and its place in the community" (p. 4). She quotes Ackerman in his belief that it is necessary, when treating an emotionally disturbed child, to also evaluate and modify the disturbances or pathology, where possible, in the child's daily personal life.

Dulicai describes her work with a middle class family consisting of a domineering mother, a passive, dependent father who tries to fulfill his emotional needs through his son, and a 17-year-old son who could not separate himself from the family. She illustrates through "family sculpting" (p. 7), the physical positions which characterize each family member's role in the family system. The family sculpture demonstrated the mother's central position, the father's dependence and the son's fear of his mother's seductiveness. Also revealed was an increase in the mother's anxiety level as the son moved farther from the family.

In this particular family, one of the major goals was in helping the son to leave the family and succeed in his adult life. Since both parents expressed an intellectual interest in this goal, Dulicai felt it was safe and feasible to expose the non-verbal "messages" around this issue which were unconsciously encouraging him to stay home. Dulicai tried the following style of intervention. Her goal was to begin decoding non-verbal communications in a non-threatening way.

> . . . The father and the movement therapist stood in a circle and, with music accompanying began a simple gesture that all were familiar with (. . . "thumbing"). The [family's] association with this was, "someone is going somewhere." At this point, the mother directly asked her son where he wanted to go. The therapist asked the son to try and mimic the gesture of the mother, for it was clear that her gesture had changed radically to message "come here" rather than thumbing "go away." (p. 10)

The above is one technique Dulicai used to expose the family to an awareness of their non-verbal communications, that is, "messaging." A second technique which utilizes "messaging" and effort/shape is described below:

> I would get a simple motion started choosing a simple rhythmic two phasic gesture and increase the intensity and decrease the strength of the gesture, then add directness so that the gesture was no longer directed to space but to another person. Observing the persons in the family and how they used strength and to whom, we would then reflect on what had happened. (p. 10)

This kind of intervention can lead to thoughtful discussion by the family on the role, thoughts, and feelings of family members. In this case the father discussed his role and how this role developed out of his past experiences.

In a movement sequence which involved the pelvis, it was noted that the mother directed herself toward her son. Because of the severity of the son's physical response, Dulicai believed it would be destructive to bring this into the family's conscious awareness at this time. She states this as one important aspect of family dance therapy, that is, knowing "what kinds of data need to be used . . . and what kinds need to be defended against" (1976, p. 11). Dulicai also emphasizes the importance of interfering with destructive family messages and at times directing hostility that might otherwise go to the child, toward the therapist. Over a period of 18 months, Dulicai helped the son differentiate himself from the rest of the family, partially by interfering with the non-verbal message he was receiving from his parents, and by bolstering his efforts to break away. At the same time, she helped the parents deal with their son's breaking away by encouraging them to find ways to satisfy their needs other than through their child.

In another article Dulicai (1977) describes her observation over an 18-month period of eight families with children ranging from 3 to 7 years of age. This study combines elements from a number of theoretical approaches. It is designed to disclose family dynamics through observing interaction which can take place in any interactional setting (e.g., playroom, clinic, dance studio).

She developed charts and an evaluation system for assessment of non-verbal factors and family interaction patterns. Her body movement assessment scale combines kinesic factors with emotional content. Based on the data assessed in this study, an instrument was developed to rate potential change within families.

The use of Dulicai's scale, "Nonverbal Assessment of Family Systems," is discussed in a 1980 article by Dulicai and Rogers. The authors conducted a four-month study of a mother/child dyad at the Developmental Center for Autistic Children in Philadelphia. The mother was reported to be chronically depressed and the child, 7 years old, was functioning at the developmental level of a 2½–3 year old child.

Parent/child evaluations were made by rating videotapes of three sessions during the study period. The resulting data were discussed, and treatment goals were based on these discussions. Further data were recorded on the basis of daily emotional growth and behavioral changes that resulted from movement therapy sessions. The goals of therapy were to promote a rapport within the family and to develop both physical and psychological dynamics that would facilitate the emotional growth of family members.

For purposes of observation and assessment, the early sessions were non-directive. The mother could play with her child in any way she wanted. The therapists encouraged her to respond to his initiation of play and try to reach him at his level, but they did not suggest any specific themes or tasks. During the first videotaped session, neither mother nor child exhibited a wide range of possibilities for a relationship. The mother seemed more concerned with her own needs than with her child's.

Based on this and continuing assessments, the individual sessions with the child concentrated on spatial clarity, phrasing, and modulation. The mother/child session focused on movement interchange, particularly those aspects relating to sharing, relationship, accommodation, and support. By the third and final videotaped session, considerable changes in movement and interaction were apparent. The mother was able to nurture her child for brief periods of time and could support him as he initiated and explored movement. The child was able to focus more fully, to complete movement phrases, to leave and return to projects, and was more spontaneous in speech.

Judith Bell (1984) has integrated a number of movement therapy techniques into her work with families. She observes the family members' everyday movements, of which they are not aware; as well as "subtle shifts in breathing, skin tones, and eye contact." (p. 194) She assigns structural and unstructural movement improvisations, which bring creative movement into conscious awareness. Also, she utilizes authentic movement, with stress on the ego's self observation, to promote understanding of the feelings and motivation underlying behavior.

Bell describes movement processes at all levels of human experience—in the formation and expression of emotions, beliefs, and values, as well as in physical action. Because she sees movement in all interactions, she finds it natural to communicate family behavior patterns as "Kinetic Translation[s]." (p. 243) This is a non-verbal re-enactment of the behavior which the family is describing in the session.

For example, Sarah, a mother in her mid-thirties, complained that her boyfriend, Dave, was trying to "break up" her relationship with her 10-year-old daughter, Susie. The therapist asked Dave to communicate symbolically through movement how he was trying to relate to Sarah and Susie. He placed the two sitting next to each other on the floor. He then stood up in front of them and tried to drive between them, separating them with his hands and trying to squeeze his face between theirs. Sarah immediately screamed that that was exactly what she was talking about!

By stripping the behavior to its bare bones through non-verbal movement, the family members communicate clearly, dramatically, and with full affective impact. Dave cannot disown his behavior or deny its emotional effect. However, he states that this first translation did not portray his true intention, and would like another chance. The therapist asks him to try a different approach. This time he gathers Sarah and Susie together in his arms in a big, tight, bear hug. Sarah's reaction is to feel suffocated and angry.

The therapist then asks Sarah to advance beyond portraying the current reality in the family, to demonstrate the way she would like things to be. Sarah structured the scene with Susie standing, and herself and David kneeling, so they would all be the same height. All three kept their hands at their sides. This not only gave Dave a clearer view of Sarah's feelings, but also gave the therapist rich material about additional themes, or "core processes," in the family's interaction, such as boundary issues between mother and daughter, and power issues between mother and boyfriend. Bell stresses, however, that the information gained through such movement improvisations should be treated by the therapist as a "hunch," to be confirmed or discounted as the treatment progresses.

Bell has organized her thinking about family interaction by adapting Will Schutz's fundamental Interpersonal Relationship Orientation (FIRO). FIRO postulates three dimensions to categorize all interpersonal phenomena: inclusion, control, and openness. Inclusion refers to "desires for belonging and togetherness, recognition of uniqueness, commitment to a relationship, and desires for attention and prominence." Control is defined as the "desire to exert or relinquish authority." The third dimension, openness, revolves around the issue of vulnerability. It encompasses the "amount of transparency or privacy sought . . . [and] the desire for personal and intimate or impersonal and distant relations." (p. 200)

Bell believes that the FIRO themes of interaction tend to proceed with the developmental stages of the treatment: inclusion in the initial phase, control in the middle phase, and openness in the end phase. (p. 233) Each theme and phase call for a different behavior and role from the therapist. She summarizes this along with typical family behaviors, attitudes, and goals for each stage, in two convenient tables.

Bell clearly uses the power of movement to affect change, and turns to it as both a first and last resort. She then clarifies her thinking, and systemizes her information through theoretical formulation and adaptation. Her work seems particularly useful to dance therapists interested in expanding their technical repertoire, but also for family therapists from other disciplines who are less familiar with nonverbal communication and the potential of body movement.

James Murphy (1979), a psychiatrist and dance therapist, has also experimented in the use of body movement as a therapeutic tool in his work with families. He describes his "experiential-educational approach," which "integrates dance and movement therapy with family therapy theories and techniques" (p. 61). Murphy's programs are exclusively for families with infants less than one year old. Groups consist of four families each, with the infants present at each session. Sessions take place in a workshop setting. Murphy believes that it is possible, on a movement level, to observe, interpret, and change the dynamics of family interactions. He makes the point that a therapist can work directly with an infant only on the non-verbal symbolic level.

For theoretical bases, Murphy refers to Klaus and Kennell (1976) who believe that patterns of family interaction and directions of infant development become established in the first days, weeks, and months of a baby's life. He also refers to Speck (1964) who focuses on the use of space in particular rooms of the house as a non-verbal indicator of parent-child dynamics.

Murphy's techniques rely on specific movement interventions and behavior changes which will reduce tension-producing and conflictual behavior patterns, and will positively affect both the harmony and stability of communications between parent and child and the healthy development of the infant.

In conclusion, dance therapists working with families are particularly concerned with patterns of nonverbal communication and interaction, combining dance/movement concepts (e.g., effort/shape) with family therapy concepts. In that both the dance therapist and the family therapist work directly with nonverbal communication and interaction, the avenue of family therapy administered through the medium of dance/movement in addition to verbalization seems quite natural.

Eating Disorders

Eating disorders is another area which has been receiving increasing public attention. Problems common to people with eating disorders including distortions in body image, low self-esteem, and difficulties with personal relationships. This population can benefit greatly from the dance therapy process, which enables them through dance/movement techniques to work directly with their bodies to alter distorted self-perceptions and thus modify self-destructive behaviors.

Susan Keir Wise (1978, 1981) is one of a growing number of dance therapists who are working with this population. Her work focuses on the use of dance/movement techniques to uncover the symbolic meanings of food for her clients.

Wise (1981) discusses her use of imagery as one way of achieving this. Citing Jung and W. Reich, she first uses movement to discharge surface tension. "Tension release techniques, such as hitting, punching, yelling, stamping, surging" (p. 97) clear the way for later relaxation exercises, which place clients in the receptive mode for guided imagery. Guided imagery techniques can then be utilized to stimulate the clients' unconscious connections to eating.

Wise describes several methods for "imaging," and provides a summary of the salient issues to be addressed. After becoming receptive, attention is focused on the body part which "appears more tense or emotionally charged" (p. 103). An image is found for that part; the image is asked to become active or interactive. The action is then followed and its meaning explored.

For example, Mary was a 34-year-old diabetic woman, 125 pounds overweight, who frequently binged herself into diabetic coma. She spent many hours in therapy hitting pillows with an encounter bat to express her anger at her husband, children, and money problems. The air thus cleared, Mary imaged:

> . . . all my fat in a big floppy ball in the middle of the room, all yellowing. . . . It was in a big slab off my middle and it was piled up high next to me. It said, ". . . I can kill you". . . . I remember a dream I had two nights ago where I had some terrible disease and I was dying. . . . (p. 102)

After this experience, Mary was able to connect to her wish to fuse with her father, the nurturing parent of her childhood. He had died of a "terrible disease" (cancer). After this insight, she was able to stay on her diet while working on the emotional issues (of dying and survival) in therapy.

Wise (1978) describes an alternative route to uncovering the unconscious motivation to overeat. This method utilizes the clients' small everyday movement habits to reveal underlying emotions.

The therapist works to create an open, trusting atmosphere in which the feelings can be expressed in their full intensity. The existence of the feelings is known to the client on an unconscious and body level, but the overeating keeps them out of conscious awareness. The only traces of these "undesirable" feelings are the small movement patterns and the excess weight.

The therapist begins the work by directing the clients attention to the movement "habit." For example, Ellen had a pattern of spreading her hands down and out in front of her as she talked. She identified that this was the same gesture she used when spreading food out in front of her for a binge. The therapist asked if "she felt like moving more of her body in the way her hands were moving." (p. 164) Although she did not trust herself to move at first, Ellen imagined diving into a pool. Eventually she allowed herself to "dive" into pillows on the floor, and "float" happily, curled into the fetal position. This brought a flood of associations about her parents, and represented a state of peace in which to retreat from the responsibilities of her life.

Wise believes that confronting a problem honestly releases energy for more growth, and increases self-esteem. This was true for Ellen. Although she loved the peaceful inactivity of the "pool"; she discovered active, physical exercises which she enjoyed doing. She gradually put together her own repertoire of large arm and body swings, often with fists clenched. Ultimately she delighted in safely lashing out her anger in group movement therapy, and going for fast, fist-swinging walks when her homelife became tense. She stopped gaining weight—although still cycled through dieting and binging. Later, as her sense of control and self-esteem continued to increase, her weight became less and less problematic.

Sexually Abused Children

Over the years, complaints of childhood sexual abuse have often been ignored or rejected as being merely projections of the accuser's own sexual drives. In recent years it has become more apparent that sexual abuse of children is a real and possibly growing problem.

Because dance therapy stresses the nonverbal expression of experiences, it is especially suited for the treatment of the sexually abused child. Generally, it is difficult for children to talk about feelings related to sexuality. It becomes even more difficult to discuss these feelings if the child was sexually abused in early childhood, particularly if the abuse occurred prior to the child's development of language and conceptualization, and/or if the child has been threatened or made to feel guilty and responsible for the abusive acts. For the child, and for the adult abused as a child, dance therapy provides an arena for expressing feelings about sexual abuse while circumventing the need to verbally describe the abuse. Through dance therapy, the abused individual can re-enact feelings and experiences with the guidance of a trained dance therapist, who helps to structure and direct the re-enactments in such a way as to reduce the patient's fear, anxiety, and guilt over the experience. How the child or adult is helped to re-experience and reintegrate the trauma of childhood sexual abuse is key to how he/she will survive the experience (Weltman, 1986).

Little has been written to date concerning this relatively new area of dance therapy. An article written by Marsha Weltman (1986) is reviewed here as an example of dance therapy with this population. In her article, Weltman describes her work with sexually abused children at the Neuropsychiatric Institute in Los Angeles and reviews the special problems and specific treatment needs of this population.

Drawing from her clinical experience (five years working with sexually abused children) and her clinical studies of Finklehor's (1985) "model of traumagenic dynamics" and Summit's (1983) "accommodation syndrome," Weltman has delineated four conflicted areas in the sexually abused child's development: sexual identity, self-esteem, relationship building, and body image. In all of these areas, basic conflicts over control and power are present.

Weltman stresses the importance of establishing a relationship of trust with the children. This is essential if they are to open up and share with an adult (the therapist) the pain, fear, anger, and humiliation of their experiences. In this connection, the therapist must listen to, believe, and respond with empathy to what the children say, never pushing them to describe their experiences in any greater detail than they are ready for. Any form of coercion will break the trust and will be experienced by the children as an additional violation.

One key element in establishing and maintaining trust is providing the children with a sense of security. "It is essential," Weltman states, "to tell the children that they deserve to be protected [they are the innocent victim] and are worthy of being loved" (p. 55). In addition, the therapist must make it clear to the children from the beginning that they will not be harmed in any way. Special signals between dance therapist and child should be designed to communicate if and when touch is going to be used in the dance therapy session. This gives sexually abused children the power to control their bodily experiences and exposures, and provides them with the feeling of personal power and control that had been taken from them.

Because of the children's need to feel they have some control over the therapeutic process, Weltman recommends "self-directed process oriented sessions" (p. 56), in which the children are allowed the space and time to move on their own with the encouragement and empathic support of the therapist. "Concrete experiences involving body awareness and [the free exploration of] personal and interactional space can restore integrity on a body level, at the core of their being" (p. 56).

Weltman provides several case examples which illustrate self-directed process oriented sessions. One example is the case of Edward, a nine-year-old who had been molested by a babysitter. In a group session in which the other children were playing spontaneously with Weltman by flopping in her lap, Edward withdrew. After engaging in frequent eye contact with Edward, Weltman motioned for him to join the game. Wanting to join but at the same time afraid of being hurt, Edward was motivated to express his conflict verbally by asking the therapist, in his own words, whether she would sexually assault him if he joined in the game. Weltman responded to his fears by firmly stating that ". . . adults don't get sexual with children around here" (p. 59). This stimulated Edward to take play items and push them together, acting out sexual intercourse. To this physical manifestation Weltman responded by clarifying Edward's concerns. She helped him label one play toy the adult and one the baby and then said, "That adult must be confused. When adults are sexual with children they are confused and need help" (p. 59). Here, Weltman was trying to relieve Edward of his guilt over being molested.

In another case example Weltman describes how Daniel, a seven-year-old boy who had been molested by an older man, was mobilized by an evocative game to act out his sexual invasion. The physicality of the game, in which the children in Weltman's group would roll up in a blanket and rock themselves, finally provoked Daniel to foist himself on one of the boys and symbolically act out his homosexual encounter. This enabled him to express nonverbally something that had been confusing and troubling to him.

Since Daniel's acting out of his emotions involved an imposition on another group member, Weltman had to step in and put limits on the movement process. She asked Daniel if anyone had done that to him. He said that someone had and indicated it was a friend. Weltman then tried to help Daniel explore other forms of expressing friendship and warmth without sexualizing these feelings. In this way she encouraged insight and clarification in place of physical acting out, and thus helped Daniel to integrate his emotions and actions in new and more agreeable ways. This was done with warmth and understanding, and was further supported by the group process.

For Melissa, age 7, sexual feelings, associations, and vocalizations were evoked by small movements of her toes and relaxation movements which involved tightening and releasing buttock muscles. At the end of her first dance therapy session, she drew a broken heart on the blackboard and printed the words "Sex Ed."

Melissa was anxious to talk about "Sex Ed" when she arrived at the second session but Weltman encouraged her to move first. She began with her usual small movements, wiggling her toes, and then exclaimed, "It feels weird. It feels like a banana. It feels like a nail" (p. 61). Weltman describes what followed:

> Suddenly her movements became increasingly large, rapid, and strong, as she began kicking and screaming frantically. I moved closer carefully, in order to support and focus her expression. When Melissa stopped, I asked what was happening. She replied that it was disgusting and she felt angry. . . . (p. 61)

Melissa went on to describe the act of being forced to watch sexual acts and then being abused herself. Weltman listened to every detail with belief and acceptance of the child, reflecting Melissa's own feelings back to Melissa through her (Weltman's) nonverbal and verbal communications. By reflecting the child's feelings, Weltman facilitated Melissa's obvious need to re-enact what had been done to her in a variety of movement configurations. After her re-enactments, which were guided by questions and responses from Weltman, Melissa would climb into Weltman's lap to be cradled and rocked. This emotional support and the feeling of trust and security were clearly essential to the success of Melissa's treatment.

In her work with sexually abused children, Weltman integrates the expression of thoughts, feelings, and memories provoked by movement and play with the development of a trusting, reflective, and non-punitive relationship in which she takes an actively protective role in the abused child's life.

Rehabilitation with Severe Head Injury Patients

Dance Therapy with patients suffering from severe head injuries is a relatively new and rapidly growing field. Jobs for dance therapists appear to be opening up more rapidly in this area than any other dance therapy area. Stephanie Katz, the present President of the ADTA, has worked extensively with head injury patients. She believes dance therapists are especially suited to work with this population because their training is both physically and somatically oriented (Katz, p.c., 1987).

Stephanie Katz and Cynthia Berrol, two leaders in the field of dance therapy rehabilitation with traumatic brain injury (TBI) patients, have been extremely active in educating other dance therapists as to the special problems facing this population. Berrol is the Coordinator of the Special Graduate Major, Dance/Movement Therapy at California State University at Hayward. Katz is the Program Director of Michigan Rehabilitation Center, Inc.

According to Berrol and Katz (1985):

> Every 16 seconds someone sustains a head injury; every 12 minutes someone dies of a head injury. . . . Approximately 700,000 individuals are admitted to hospitals each year as a result of severe cerebral insults. Of the survivors, upwards of 70,000 suffer marked, pervasive and long-term disruption of all domains of human function—physical, cognitive and psycho-social. Every facet of life is significantly altered. . . . Regardless of the level of recovery, a somewhat different person will emerge, a seeming stranger. . . . (p. 46)

TBI patients suffer emotionally, physically, socially, and cognitively. Various degrees of paralysis and/or neurogenic movement disorders are common results of severe head injuries. Other physical problems which may occur are spasticity, ataxia, tremors, sensory impairments, and perceptual-motor difficulties. In the cognitive realm, disorientation, lack of initiative, and poor memory and attention are frequently seen.

Berrol and Katz explain that even in cases of severe injury, the brain has some ability to repair itself. They describe several types of neuroplasticity, that is, the brain's capacity to dynamically reorganize its means of operating. For example, some brain functions are gradually restored after the swelling of brain tissue following trauma subsides. There is also a process called collateral sprouting, ". . . by which axons from intact regions of the brain send out axonal 'shoots' to the damaged zones to form new synaptic connections. . ." (p. 49). In addition, there are indications ". . . that axons and synaptic connections which are not normally responsible for a particular function may take over when the primary or dominant system is disrupted . . ." (p. 50). Berrol and Katz point out that other factors also have an influence on the degree of dynamic reorganization of the brain after trauma. These include age (being younger is an advantage), environmental factors (social interaction is an important part of rehabilitation), and drug treatment.

Frequently in their group work with TBI patients, the authors divide their sessions into a warm-up, a theme development phase, and a closure. The warm-up is designed for five purposes:

1) *To organize the group.*

2. *To organize the body.* They utilize ". . . a traditional warm-up of nonlocomotor type movement using body parts first in isolation and progressing to a coordinated use of the whole [body]. . . ." (p. 54). Movement opposites, range and dynamics are also explored. Specific movements are introduced depending on individual needs.

3) *To stimulate cognitive processes.* Using imagery stimulates the symbolic process. Asking questions which encourage reflection on internal sensations, feelings, memories, and images helps to strengthen conceptualization and broaden the movement repertoire.

4) *To support group interaction and stimulate social awareness and a feeling of community.* When the group is ready, the leader relinquishes the role of movement provider and encourages the patients to take over. As group members alternate assuming this role, their independence, sense of initiative and leadership are promoted.

5) *To lay the groundwork for subsequent theme development.*

During the theme development phase of the group, issues of dependence versus independence are frequently dealt with. These are immediately relevant and potent issues. TBI patients find themselves suddenly thrust into a totally dependent situation in which they are continually being manipulated, pushed here and there, directed, and controlled. Each patient reacts to this differently, some with extreme compliance and others with rage and aggression. For this reason the leaders try to engage patients around these issues so that they can deal with them within the group.

Several group structures done in dyads are suggested by Berrol and Katz. One of these is called sculpting, a technique by which one patient sculpts another in space. The patient who was first instructed to be passive while being sculpted (i.e., physically placed into a specific shape or poise) is then told to resist being molded. Another movement dyad technique which encourages issues of personal strength and independence involves the use of large stretch bands, with the participants working to keep the band taut. A third dyad technique involves having one partner say "yes" while the other says "no," continuing until one gives in and says the other's word. These and other similar techniques evoke feelings and discussion among participants around issues of dependency, anger, fear, and so on. Common problems and frustrations are aired, and group support and further movement development and reflection are facilitated. These structures also promote, specific kinds of muscle activity awareness, and coordination.[1]

The closure of the group session promotes further benefits for this population. Closing techniques involving breathing and relaxation increase the individual's ability to attend to his/her internal sensations and in this way facilitate the development of a more intact body image. Recalling what happened in the session as a kind of summation fosters the ability to remember. "The importance of this sort of cognitive exercise, verbal and/or motoric repetition as a therapeutic technique with . . . this population cannot be overemphasized" (p. 56).

Berrol and Katz provide two case studies in their article. The one which will be briefly described here was conducted by Katz at the Therapeutic Recovery Program in Southfield, Michigan. This is the case of D., a 22-year-old man who suffered TBI in a car accident. D. was confined to a wheel chair. He could not feed himself, write, or even go to the bathroom without help. He also suffered from partial facial paralysis, and impaired intellectual and proprioceptive functioning. His behavior revealed depression and impulsivity. Prior to his accident he had prided himself on his independence, prowess, and reckless qualities.

Katz, seeing his need for freedom and unconventional treatment techniques, provided him with the time and space he needed to explore movement in his own way.

> We developed a technique of D. sliding out of his wheel chair to the floor with my assistance so he could stretch out and feel the length of his body. Rolling across the room provided the freedom in space he so dearly missed. Pressing his lengthened body on the floor allowed

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[1] When working with these patients a thorough knowledge of the body and the effects of the trauma are necessary, or severe injury could accidentally occur.

> for kinesthetic feedback as to more correct alignment of his spine and head. He was able to use . . . the mirrored wall . . . to make necessary adaptations. . . . D's true joy, however, was using the full space of my room, trying new movement activities. . . . (p. 63)

The key to the success of Katz's work with D. was her ability to feel comfortable with D's needs for space, freedom, and unconventional movement exploration. The traditional equipment used for rehabilitation was too confining for D. When Katz gave him the freedom he needed to feel in control of his body and his space, he became an active participant in his own recovery and proud of his achievement.

Summary

Dance therapy with brain injured patients focuses on developing awareness, cognition, motivation, concentration, control, and memory. Emotional issues are also important for this population. Dealing with feelings of anger, frustration, remorse, and loss are all aspects of treatment, as well as dealing with pressing issues of dependency, sexuality, autonomy, and others. Some of these goals, and the methods used to achieve them, overlap with those of dance therapy with other populations. For example, work with the physically handicapped also focuses on issues of dependency and on "activating and motivating" patients—Bartenieff's main themes in her work with that population. In addition, the cognitive development, stressed by Berrol and Katz, is also a goal of dance therapists who work with learning disabled children, particularly those with organic brain disorder. However, Berrol and Katz are also charting new waters. As TBI research continues, a whole new body of knowledge and dance therapy technique is developing.

The dance therapist's work with TBI patients is complemented but not duplicated by the work of the occupational and physical therapists. The latter, according to Katz (p.c., 1987), are more task-oriented. The occupational therapist stresses development of dexterity in the upper body, fingertips to shoulder, and activities of daily living. The physical therapist emphasizes development of the lower half of the body (gait training, adjustment to braces, etc.), and skill acquisition. In contrast, the dance therapist works with the whole person. Movement is the vehicle with which all aspects of the individual's life—emotional, cognitive, social and physical—can be dealt (Katz, 1987, p.c.).

Another important center for the rehabilitation of TBI and other traumatic injury patients is the New England Rehabilitation Hospital in Massachusetts. Currently Lou Cannon is in charge of the Hospital's dance therapy department. Excellent videotapes of the work which Cannon and her staff[2] are doing were shown at the 1987 American Dance Therapy Association's annual conference in Los Angeles.

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[2] The staff includes Ann Cole, Susan Cotter, Ruth Lefcovich, Monica McNamara, Linda Murrow, Margaret Snider-Nieman, and Dawn Werme.

UNIT III

Survey Results and the Evolution of Dance Therapy

The purpose of this text has been to present a comprehensive examination of dance therapy, attempting to organize and define pioneering and leadership roles in the field and to acknowledge the contributions of leading dance therapists. To facilitate this process, a survey was sent in the spring of 1985 to approximately 235 ADTR's (Academy of Dance Therapists, Registered—a designation made by the American Dance Therapy Association). Because the author was seeking a sample of experienced dance therapists, those who received the survey had to be in the Academy by 1980. The author hypothesized, first of all, that most of the therapists meeting the 1980 requirement would have been practicing for an average of 12 years.[1] Second, it was expected that this sample would represent a high percentage of leadership in the field. This high leadership factor was essential if the survey was to prove useful as a barometer of where dance therapy has been, where it is now, and where it is going. Indeed, it is the contemporary leaders who reflect the strengths and weaknesses of past and present influences and who set the pace for future trends.

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[1] Twelve years represents a reasonably substantial amount of time for clinical practice in a profession which itself is only slightly more than 40 years old.

Both predictions proved true. An analysis of the leadership criteria question revealed that more than sixty-five percent of the respondents demonstrated extremely high leadership, while the remaining respondents demonstrated moderate to high leadership. In addition, the average number of years the respondents had practiced dance therapy was 14 years.

This unit revolves around the results of the survey (see appendix for a sample survey). Section A traces dance therapy trends based on an analysis of the past and present influences on the respondents' work, and on statements made by the respondents concerning changes in theory and practice. Because of the small size of the sample, these findings are not conclusive. However, due to the high leadership represented in the sample as well as the length of time the respondents have been practicing, the findings can serve as a guide in assessing the past, present, and future trends.

Section B includes the dance therapy heritage trees. These trees trace the spread of influence of seven pioneers—Chace, Whitehouse, Evan, Espenak, Schoop, Hawkins, and Bartenieff—on the survey respondents.

SECTION A

Review of Survey Findings

This comprehensive survey required a great deal of time and thought on the part of the respondents. The goal of the survey was to explore changing trends in the theory and practice of dance therapists and to understand the foundations on which dance therapy was built.

To accomplish this goal the respondents were asked to list significant influences on their work in the areas of dance, psychology, and dance therapy. In addition, an assessment of the relative overall importance of certain areas was requested and compared. These areas were dance, LMA training, dance therapy training, psychological theory, one's own experiences as a participant in dance therapy, and one's own experience as a participant in verbal therapy.[1] Respondents were asked to differentiate between those influences which were most important in the early part of their careers and those influences which are now important. Finally, respondents were asked to briefly state any significant changes which have taken place in their theoretical and/or practical orientation. The following is a discussion of the results.

Dance Influences

Since dance therapy arose out of the modern dance movement, with all the pioneers having started their careers as performers, choreographers and/or dance teachers, one part of the survey focused on the particular dance influences affecting the respondents' work. The respondents were asked to name the most influential styles of dance and/or dance teachers, and could list as many as they wanted. Only those receiving 6 or more responses are documented (see Tables 1 and 2).

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[1] It is well known that a psychotherapist's own therapy is an important part of his/her training and often considered a prerequisite for any kind of advanced clinical training. A similar sentiment exists in the dance therapy field. For this reason we thought it especially important to find out what kind of therapy experiences dance therapists sought and what they found most helpful.

TABLE 1

Influential Dance Styles

Styles	No. of Responses
Modern	72
Improvisation*	34
Ballet	31
Folk	21
Afro	13
Jazz	12
Ethnic	12
Creative	11
Mime/Pantomine	6

*Improvisation is an aspect of modern dance.

According to the findings, modern dance is clearly the dominant influence on dance therapy. This is not surprising since modern dance was itself propelled by the need for intense emotional and intellectual expression and psychological probing. It is surprising, however, that only 11 respondents cited creative dance as an influence in their work. Many of the dance therapy pioneers—notably Evan, Espenak, Polk, Boas, and Hawkins—had extensive training in creative dance and believed strongly in its power as a medium for self-expression. One explanation could be that creative dance was frequently' integrated into modern dance classes, but was not always labelled as such.

TABLE 2

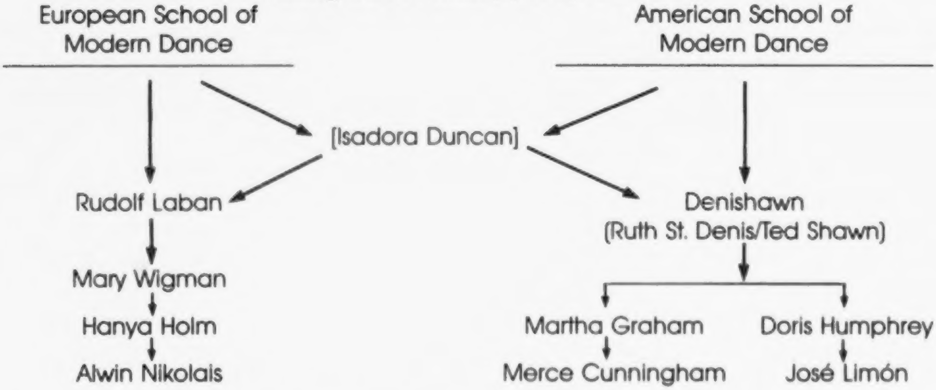
Influential Dance Teachers (Direct and Indirect)

Dance Teacher	No. of Responses
Martha Graham	24
José Limón	17
Merce Cunningham	11
Alwin Nikolais	9
Rudolf Laban	8
Hanya Holm	8
Mary Wigman	7
Isadora Duncan	7
Margaret H'Doubler	7
Doris Humphrey	6

The breakdown of influential dance teachers also confirms the continuing and widespread influence of modern dance on today's dance therapists. All of the dance teachers who were cited at least six times by the respondents are from either the European or the American school of modern dance. The only possible exception is Isadora Duncan, whose work cannot be easily categorized. While many consider Duncan to be an original pioneer of modern dance, others refer to her work as either experimental or interpretive.

The data in Table 2 is presented below in the form of a modern dance heritage tree, depicting the lineage of each dance teacher within the American and European schools of modern dance.

Spread of Modern Dance Influence Among Dance Therapy Respondents



Although the Denishawn school was never cited, Denishawn descendants Martha Graham and Doris Humphrey were. This might be explained by the fact that both Graham and Humphrey branched out from Denishawn to make their own unique contributions, and as a result, they and their descendants are not frequently associated with the Denishawn school of dance. Moreover, Graham, who was cited more frequently than any of the other dance teachers, is considered by many to be the original pioneer of modern dance. Innovators St. Denis and Shawn, however, were from a much earlier period.

To get a more complete picture of the role of dance in dance therapy, the dance influence must be viewed in relation to other influences. In this connection, the respondents were asked to rate the degree of influence, both in the past and present, that each of the following factors had on their work: dance, Laban Movement Analysis, dance therapy training, psychological theory, being a client in dance therapy, and being a client in verbal therapy.

In order to explore the possibility that areas of influence may have shifted for the younger generation of dance therapists, the results were grouped into two categories of respondents: those dance therapists in the field for 15 or more years (the 15+ group), and those in the field for 13 or fewer years (the 13− group).[2]

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[2] This breakdown resulted in two groups of equal size, with 45 respondents in each category. The 6 respondents who fell between the two groups were eliminated from these analyses, but are included in the data for the total field. The figures in Tables 3, 4, and 5 were rounded off to the nearest percentage. As a result, the totals across each category add up to 100% plus or minus 1%.

Mary Wigman in performance. (Photo courtesy New York Public Library.)

TABLE 3

Degrees of Influence: 15+ Group (45 Respondents)

Early Influence	Highly	Moderately	Least	Not Rated
Dance	82%	4%	2%	11%
LMA	22%	16%	11%	51%
Dance Therapy Training	71%	9%	2%	18%
Psych. Theory	44%	27%	7%	22%
Client in Dance Therapy	22%	7%	4%	67%
Client in Verbal Therapy	24%	24%	9%	42%

Current Influences	Highly	Moderately	Least	Not Rated
Dance	64%	16%	9%	11%
LMA	22%	31%	9%	38%
Dance Therapy Training	49%	24%	4%	22%
Psych. Theory	67%	18%	7%	9%
Client in Dance Therapy	24%	13%	7%	56%
Client in Verbal Therapy	44%	9%	16%	31%

TABLE 4

Degrees of Influence: 13– Group (45 Respondents)

Early Influences	Highly	Moderately	Least	Not Rated
Dance	73%	11%	9%	7%
LMA	29%	38%	11%	22%
Dance Therapy Training	78%	13%	4%	4%
Psych. Theory	49%	33%	11%	7%
Client in Dance Therapy	22%	13%	4%	60%
Client in Verbal Therapy	29%	27%	20%	24%

continued on p. 268

Mary Wigman. (Photo courtesy New York Public Library.)

TABLE 4 (continued)

Current Influences	Highly	Moderately	Least	Not Rated
Dance	49%	22%	18%	11%
LMA	38%	24%	18%	20%
Dance Therapy Training	53%	29%	11%	7%
Psych. Theory	62%	20%	13%	4%
Client in Dance Therapy	22%	9%	7%	62%
Client in Verbal Therapy	42%	20%	20%	18%

TABLE 5

Degrees of Influence: Total Field (96 Respondents)

Early Influences	Highly	Moderately	Least	Not Rated
Dance	77%	8%	5%	9%
LMA	23%	27%	12%	39%
Dance Therapy Training	70%	12%	3%	16%
Psych. Theory	51%	27%	7%	15%
Client in Dance Therapy	24%	10%	5%	61%
Client in Verbal Therapy	26%	22%	15%	38%

Current Influences	Highly	Moderately	Least	Not Rated
Dance	55%	19%	14%	13%
LMA	28%	28%	15%	29%
Dance Therapy Training	48%	28%	7%	17%
Psych. Theory	64%	18%	9%	8%
Client in Dance Therapy	24%	10%	9%	56%
Client in Verbal Theory	41%	16%	17%	27%

Tables 3, 4, and 5 indicate that the strongest influences in the past and the present have been dance, dance therapy training, and psychological theory, though to differing degrees for each group and with changes over time. Interestingly, for both groups the influences of dance and dance therapy training have decreased, while the influence of psychological theory has increased.

While the importance of dance has declined for both groups, it was and still is a stronger influence for the 15+ group. One possible explanation may lie in the fact that the process of professionalizing the field of dance therapy began only 20 years ago. Therefore, many of the older generation had strong backgrounds in professional dance before becoming dance therapists, some moving into dance therapy at a midpoint in their dance careers and a few in the latter part of an already well-developed profession as performers, choreographers, and/or dance teachers (see Table 6). One can see how dance would be the major influence for this group, especially in the early part of their dance therapy careers.

In contrast, with the advent of formal academic programs in dance therapy and recognized job lines, the younger generation was more likely to be informed of this option early in their dance training and general education. This would have enabled them to gear their interests toward a career in dance therapy rather than in professional dance, and account for the overall lower influence of dance for this group.

TABLE 6

Dance Performance, Choreography, Teaching Dance

	15+ Group	13− Group	Total Field
Dance Performance:			
Major Influence	: 56%	: 36%	: 45%
Minor Influence	: 31%	: 38%	: 32%
Not Applicable	: 13%	: 27%	: 20%
Choreography:			
Major Influence	: 62%	: 42%	: 50%
Minor Influence	: 20%	: 20%	: 20%
Not Applicable	: 18%	: 38%	: 28%
Teaching Dance:			
Major Influence	: 69%	: 53%	: 59%
Minor Influence	: 13%	: 18%	: 17%
Not Applicable	: 18%	: 29%	: 21%

The survey indicated that the average number of years of dance training for the respondents is 20+ years. Generally, a solid dance education is very much a part of the lives of dance therapists, and many respondents noted that their dance education continues today.

Nevertheless, it can be speculated that the difference in professional dance experience is a contributing factor to the different stress that each group places on dance. It may also be a contributing factor to the difference in the influence of Laban Movement Analysis.

As indicated in Tables 3 and 4, the LMA influence is not rated highly by a large percentage of the respondents in either group; however, it has increased in importance for the 13− group while remaining the same for the 15+ group. It is possible that many of the older generation, because of their rich and diversified dance backgrounds, had already internalized the aspects of LMA inherent in a thorough modern dance education, while the younger generation may be making up for deficits through LMA training.

Psychological Theory and Its Relationship to the Dance Influence

The most significant factor affecting the decreasing influence of dance is perhaps the increasing influence of psychological theory. As shown in Tables 3 and 4, theory has become the most important influence on the current work of both the 15+ and 13− groups.

Dance therapists are for the most part eclectic. According to the survey findings, a large majority of the respondents have been influenced by three or more psychological theories.

TABLE 7

Number of Psychological Theories Influencing Respondents

	1 Theory	2 Theories	3 or more Theories
15+ Group	9%	11%	80%
13– Group	8%	20%	72%

TABLE 8

Influential Psychological Theories

Psychological Theory	15+ Group	13– Group	Total Field
Psychoanalytic*	32	28	64
Freud	9	8	19
Jung	6	11	19
Ego Psychology	4	4	10
Object Relations	5	8	15
Gestalt Therapy	7	9	16
Developmental	8	5	14
Humanistic	6	2	10
Group Dynamics	7	4	11
Interpersonal	5	3	8
Systems Theory (including Family Systems and Family Therapy)	4	4	8

*Of the many subcategories of psychoanalytic theory, only Freud and Jung were mentioned frequently enough to warrant inclusion.

While psychoanalytic theory is by far the most influential for both groups, it is also clear that the respondents as a whole have been influenced by a wide variety of other theories. These include those listed in Table 8, as well as many others which were cited only once or twice and which varied tremendously among the respondents, for example, behavioral, bioenergetic, psychodrama, transpersonal, and many more.

Dance therapists on the whole, according to the findings, see the value in understanding their movement work in theoretical terms. This has often led them to investigate established theories and relate them to their clinical experiences. The dance therapists' ability to integrate established psychological theory into their work serves the purpose of linking dance therapy more directly to other psychotherapies, thus aiding communication among the various mental health disciplines. In addition, it can at times help dance therapists to broaden and clarify their observations and insights into the sometimes amorphous and often confusing nonverbal aspects of dance therapy. This is undoubtedly the role which theory plays for all psychotherapies.

Another factor contributing to the increasing influence of psychological theory is the tacit

Isadora Duncan, Parthenon Theatre, Athens, Greece, 1904. (Photo courtesy New York Public Library.)

pressure exerted on dance therapists, from both outside and within the discipline, to bring dance therapy more in line with traditional and established forms of psychotherapy. Dance therapists too often speak a language unfamiliar to the broader community of mental health. Thus, they are, at times, still in position of trying to prove their worth to those who view dance therapy as esoteric, ancillary, and/or recreational rather than as a legitimate, in-depth treatment approach. This has put pressure on dance therapists to explain their work publicly on more complex levels than previously required. This could account, in part, for the greater influence of psychological theory in recent years.

As a result, dance therapy is becoming assimilated into the larger mental health community.

As we know, assimilation always has its positive and negative features. Gaining more acceptance within the field of mental health is a positive result of this process, as are the many contributions of dance therapists in integrating personality and development theory into the theory and practice of dance therapy. On the negative side, however, it can be argued that dance therapy is losing its uniqueness, as reflected in the decreasing influence of dance on dance therapy practitioners.

In light of economic pressures and pressures to conform and enter the mainstream of the mental health profession, one can see how it would take great strength and a deep commitment to the values of dance to maintain an emphasis on this aspect of dance therapy. It is not surprising that some dance therapists are beginning to feel that the dance aspects of their work are being threatened.

This conflict was elaborated further when respondents were asked to describe any noteworthy shifts in either the theory or practice of their work. The two shifts reported most frequently were: 1) a shift toward a greater emphasis on and/or reaffirmation of the importance of dance in dance therapy; and, 2) a shift toward in-depth psychological training as the theoretical foundation of dance therapy.

As for the respondents who indicated a move toward dance, some respondents said dance is the most important aspect of their work; some said they have moved back from an emphasis on psychological theory to an emphasis on dance; others noted that they have moved from a Chacian approach to a Whitehousian or authentic movement approach to dance therapy; and finally, a few indicated their concern that the profession is losing the dance in dance therapy by becoming too theoretical and thus removed from the essence and power of dance.

Among the respondents who noted a shift toward psychological training, some noted that they have moved from a pure movement orientation to the incorporation of a particular psychological framework as the basis for their work; others said they have shifted from one psychological framework to another. The theoretical area cited most frequently by these respondents was psychoanalytic. It is important to note that of all the individuals who indicated this shift, only a few said they were moving away from dance. One respondent stated she has shifted toward a "developmental perspective, i.e., psychology of self, ego psychology, etc., while continuing to develop the art of the dance in the process."

While the trend toward an increasing influence of psychological theory remains strong, there are indications that the accompanying trend toward a decreasing influence of dance may be slowing down and, perhaps, even beginning to reverse itself. One may speculate that dance therapists are coming to realize that there need not be a conflict between these two aspects of their work and that, in fact, they can support and strengthen each other. These changes in the field are part of the maturation process that any discipline needs to experience if it is to challenge itself and grow.

Dance Therapy Training and Dance Therapy Infleunces

As shown in Tables 3 and 4, the influence of dance therapy training has dropped in recent years for both groups of respondents. Nevertheless, it still remains relatively important overall, ranking second for the 13− group and third for the 15+ group. The younger generation, according to the other survey findings (see Table 9), is significantly more eclectic in their dance therapy training, a large majority having had three or more dance therapy trainers.

TABLE 9

Number of Dance Therapy Trainers

	No Trainers	1 Trainer	2 Trainers	3 Trainers
15+ Group	11%	27%	20%	42%
13− Group	0%	8%	16%	76%

Being a client in dance therapy has remained relatively stable over time as an influence for both groups (see Tables 3 and 4). However, compared with the other influences it has generally not been important overall.

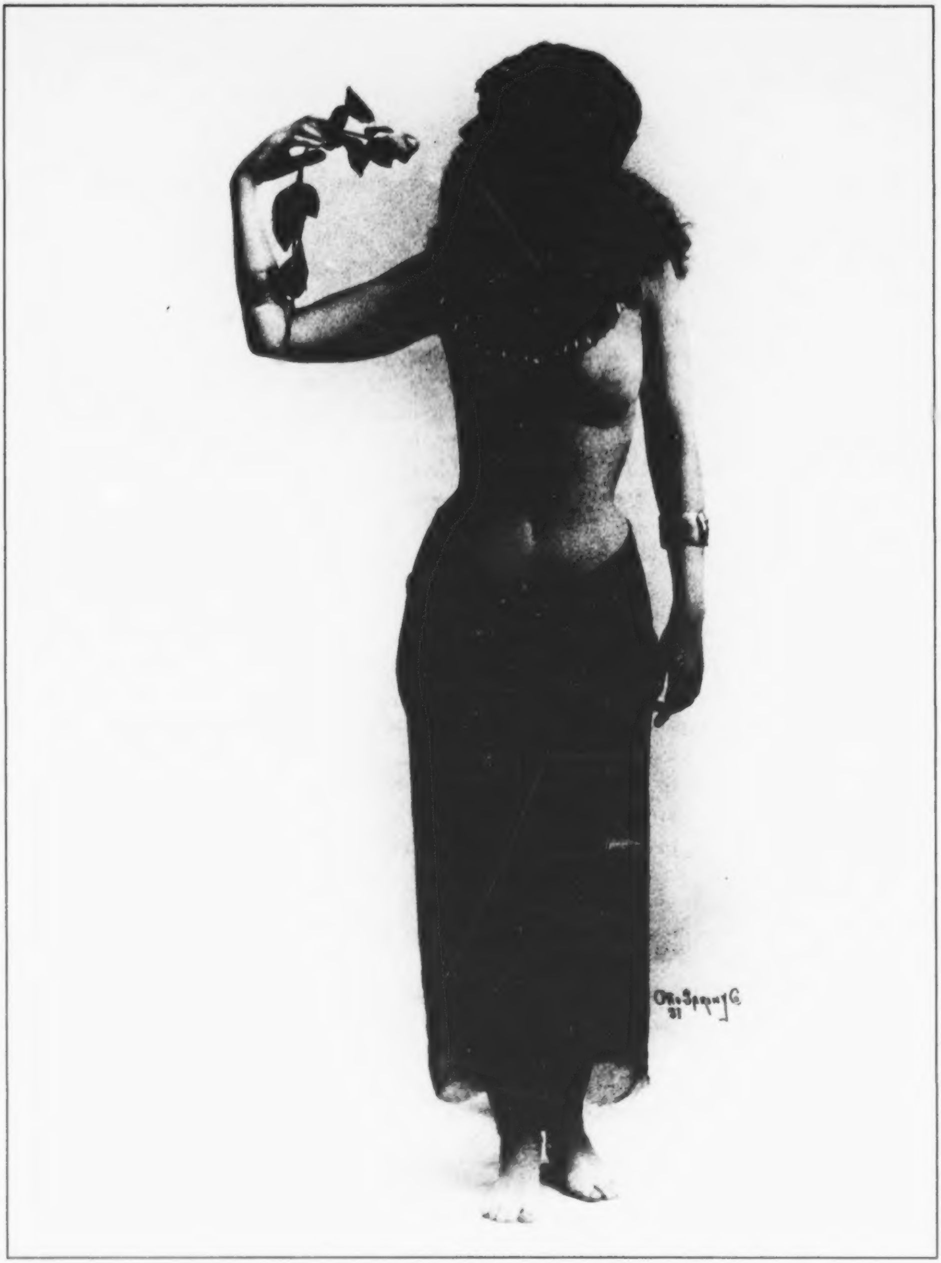
Verbal Therapy and Verbalization

Verbal therapy (specifically, personal psychoanalysis) is frequently a prerequisite for becoming a psychoanalyst and has in recent years become more common among dance therapists. As shown in Tables 3 and 4, being a client in verbal therapy has risen significantly as an influence on the work of both groups of respondents. This raises a question as to why dance therapists, in seeking continued personal and professional growth, seem more likely to turn to verbal therapists than to their fellow dance therapists.

One hypothesis, relevant especially for the 15+ group but also to a certain degree for the 13− group, is that they tend to seek those outside the field for reasons of confidentiality, since their fellow dance therapists are often their peers, friends, and colleagues. More importantly, the healing aspects of dance for both groups have perhaps already become an integrated part of their lives, whereas the verbal idiom as an expressive and exploratory modality may still need development. Finally, up until the 1970's, there were very few dance therapists doing in-depth individual treatment.

Since dance therapists frequently go to verbally oriented psychotherapists, one might ask if they are increasing their use of verbalization in their work. If so, is this contributing to a decrease in the use of dance/movement? Although the survey did not specifically ask respondents about their use of verbalization, in response to the question concerning shifts in dance therapy theory or practice several respondents did note that they are including more verbalization in their current work. These respondents on the whole did not indicate whether the dance/movement aspects of their work have become any more or less important as a result of this shift. We can only speculate that the use of verbalization may be replacing some aspects of dance/movement for some dance therapists, while for others it may have the effect of simultaneously deepening and broadening movement expression. One respondent stated, "I used to view myself as a dance/movement therapist who could talk; I now see myself as a psychotherapist who knows how to use movement."

Different people grow from different experiences. At the extreme ends of the spectrum, some individuals need an almost purely verbal form of expression, while others may require an almost purely physical mode of expression. However, more often than not, different individuals at different times require varying combinations of psychic and somatic work. The expressive and exploratory needs of most patients are bound to change many times in the course of dance therapy treatment, especially in the case of long-term treatment, demanding



Ruth St. Denis in performance, 1904. (Photo courtesy New York Public Library.)

verbal and dance/movement approaches alternately. Thus, dance therapists will by necessity alternate between movement, verbalization, and possibly other idioms as well.

The shift toward more verbalization goes hand in hand with another shift, that is, the shift toward dance therapy as a primary therapy, also noted by respondents.

Other Shifts

Other shifts were reported. One was a shift toward systems theory, particularly family systems. Some respondents indicated that they work with families, while others noted they use the systems theory as a framework for their work with various populations.

The other shift was toward the incorporation of the spiritual into dance therapy. Several respondents indicated a shift toward one or more of the following: spirituality, Jungian thought, ritual movement, and/or transpersonal and transformational experiences.

This move toward spirituality is not surprising in light of the history and meaning of dance. Throughout almost all of the literature on dance, be it folk or primitive, ballet or modern, there is continual reference to various forms of faith and spirituality. Dance has often been attributed with magical and transformational powers. It has served as a form of prayer and meditation and as a way to reach the collective unconscious. In addition, some of the major dance mentors, including Wigman, Holm, and Boas, spoke often of the spiritual aspects of dance.

In current times, there appears to be a resurgence of faith and spirituality expressed in many different forms throughout society as a whole, and since this element has always been present in dance, it is not surprising to find this same resurgence among dance therapists. It is possible that this trend toward spirituality is one contributing factor in the trend toward a reaffirmation of the dance aspects of dance therapy.

Summary

The survey findings indicate that the discipline of dance therapy continues to grow and expand and within that growth and expansion dance therapists struggle to sort out their professional identities. The question of how to view oneself professionally is not, however, unique to dance therapists. With the proliferation of contemporary psychotherapies, all mental health professionals have to carefully consider and choose their treatment styles. The question which is unique and pressing for today's dance therapists, however, is how to incorporate complementary theory and practice borrowed from the more traditional verbal psychotherapies, while still remaining true to their belief in the healing powers of the dance. This is further complicated by the financial and political pressures confronting today's dance therapists.

SECTION B

Dance Therapy Heritage Trees

This section includes the heritage trees representing the spread of dance therapy influence on the survey respondents. Individual trees were constructed for the six major dance therapy pioneers discussed in Section I (Chace, Whitehouse, Evan, Espenak, Hawkins, and Schoop) as well as for the LMA/dance therapy pioneer Irmgard Bartenieff. According to the survey findings, these individuals influenced the largest number of first generation dance therapists, and on this basis were selected for inclusion in this section.

MARIAN CHACE

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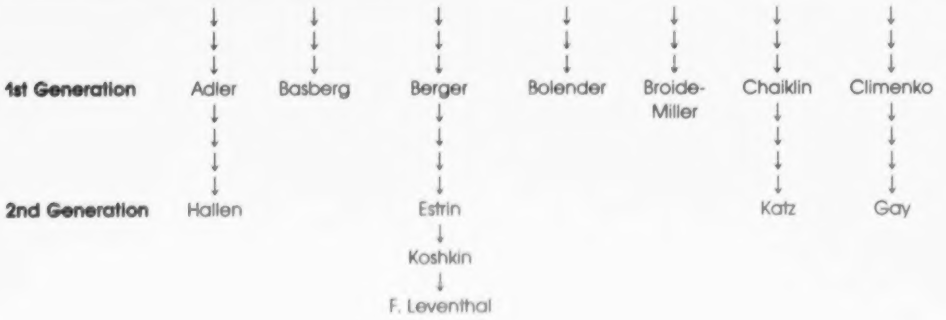
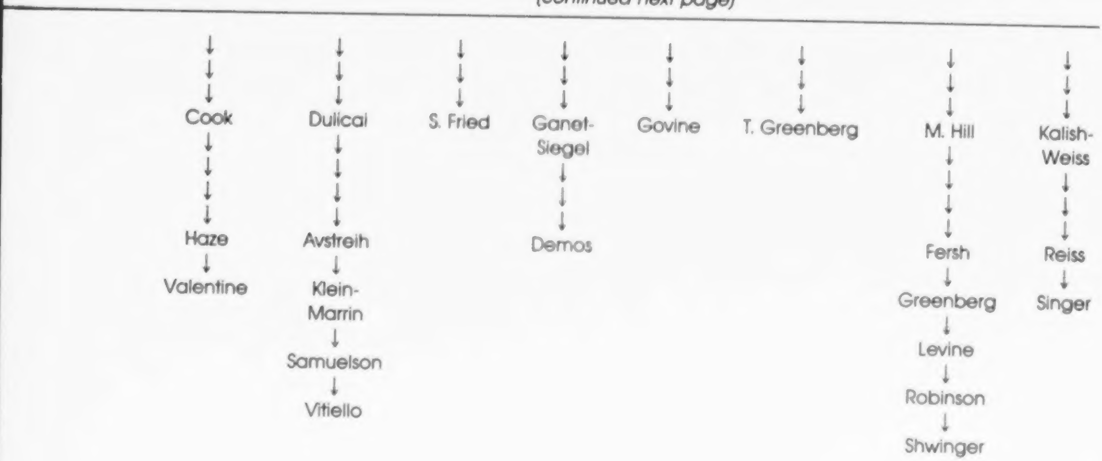

1st Generation
Adler
Basberg
Berger
Bolender
Broide-Miller
Chaiklin
Climenko
2nd Generation
Hallen
Estrin
Koshkin
F. Leventhal
Katz
Gay

MARIAN CHACE

(continued next page)


Cook
Haze
Valentine
Dulical
Avstreih
Klein-Marrin
Samuelson
Vitiello
S. Fried
Ganet-Siegel
Demos
Govine
T. Greenberg
M. Hill
Fersh
Greenberg
Levine
Robinson
Shwinger
Kalish-Weiss
Reiss
Singer

MARIAN CHACE

(continued next page)

1st Generation	Klein	Kleinman	Lewis	Olin	Pasternak	Puder	Sandel	Schmais
2nd Generation	Estrin Levy	Cowdery Hallen	Binder Loman		Fletcher		Aiudi Kuettel Loman	Avstreih Berkowitz Cassell DiPalma Duggan Fersh Gay Hamburg Koch Kuettel Levine Reiss Serlin Studenroth Truppi-Hoff

MARIAN CHACE

(end)

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Silberman-Diehl

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Schmitt
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Blau
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Fersh
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Reiss
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Van Wart

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Sonen (Paulsen)
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Aiudi
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Gay

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Stark

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Strauss
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McCall

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Thomas

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Weiner
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Gay
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Aiudi

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E. White
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Avstreih
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Berkowitz
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Cassell
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DiPalma
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Duggan
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Gay
↓
Hamburg
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Koch
↓
Keuttel
↓
F. Leventhal
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Reiss
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Serlin
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Studenroth
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Truppi-Hoff

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G. White
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↓
McCall
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IRMGARD BARTENIEFF

(continued next page)

1st Generation	Berger	Bolender	Broide-Miller	Cannon	Chaiklin	Chambliss-Mackie	Cook	Duggan	Dulicai
2nd Generation							Haze		
							Stanton		

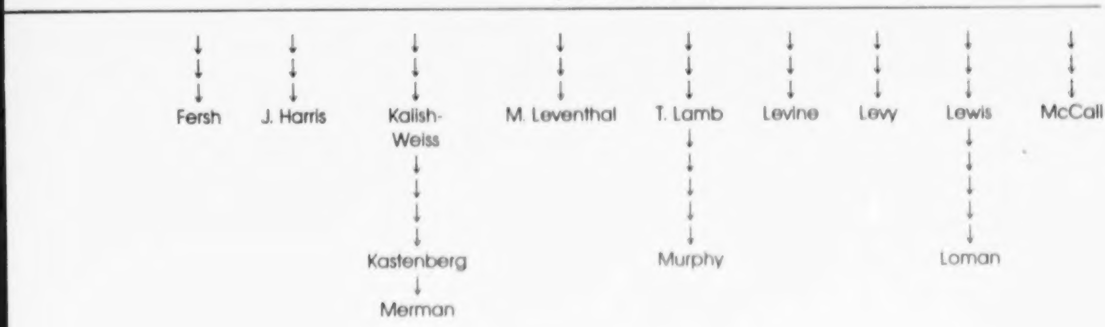
IRMGARD BARTENIEFF

(end)

1st Generation	Paulay	Penfield	Rifkin-Gainer	V. Reed	Robinson	Sandel	Serlin	Silberman-Diehl	Willis
2nd Generation	Cassell			Estrin					
				Koshkin					
				F. Leventhal					

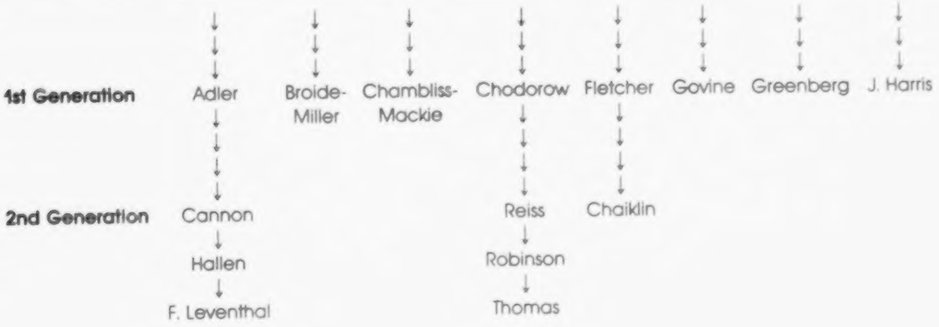
IRMGARD BARTENIEFF

(continued below)


Fersh
J. Harris
Kalish-Weiss
Kastenberg
Merman
M. Leventhal
T. Lamb
Murphy
Levine
Levy
Lewis
Loman
McCall

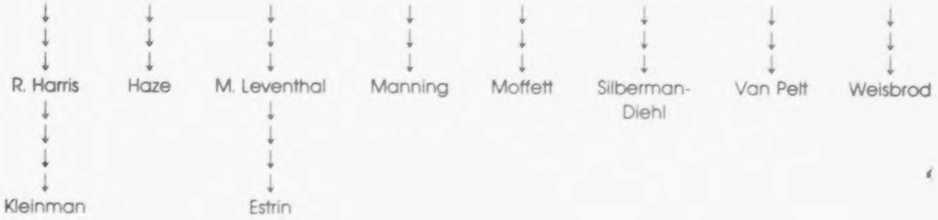
MARY WHITEHOUSE

(continued next page)

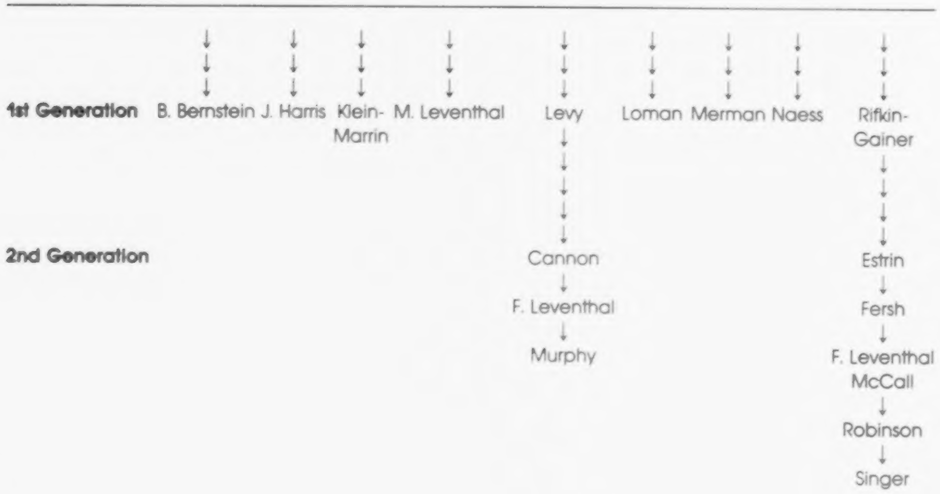

1st Generation
Adler
Broide-Miller
Chambliss-Mackie
Chodorow
Fletcher
Govine
Greenberg
J. Harris
2nd Generation
Cannon
Hallen
F. Leventhal
Reiss
Robinson
Thomas
Chaiklin

MARY WHITEHOUSE

(end)

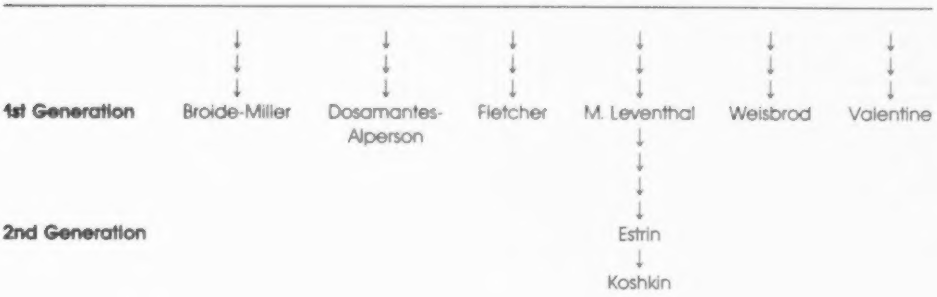

R. Harris
Kleinman
Haze
M. Leventhal
Estrin
Manning
Moffett
Silberman-Diehl
Van Pelt
Weisbrod

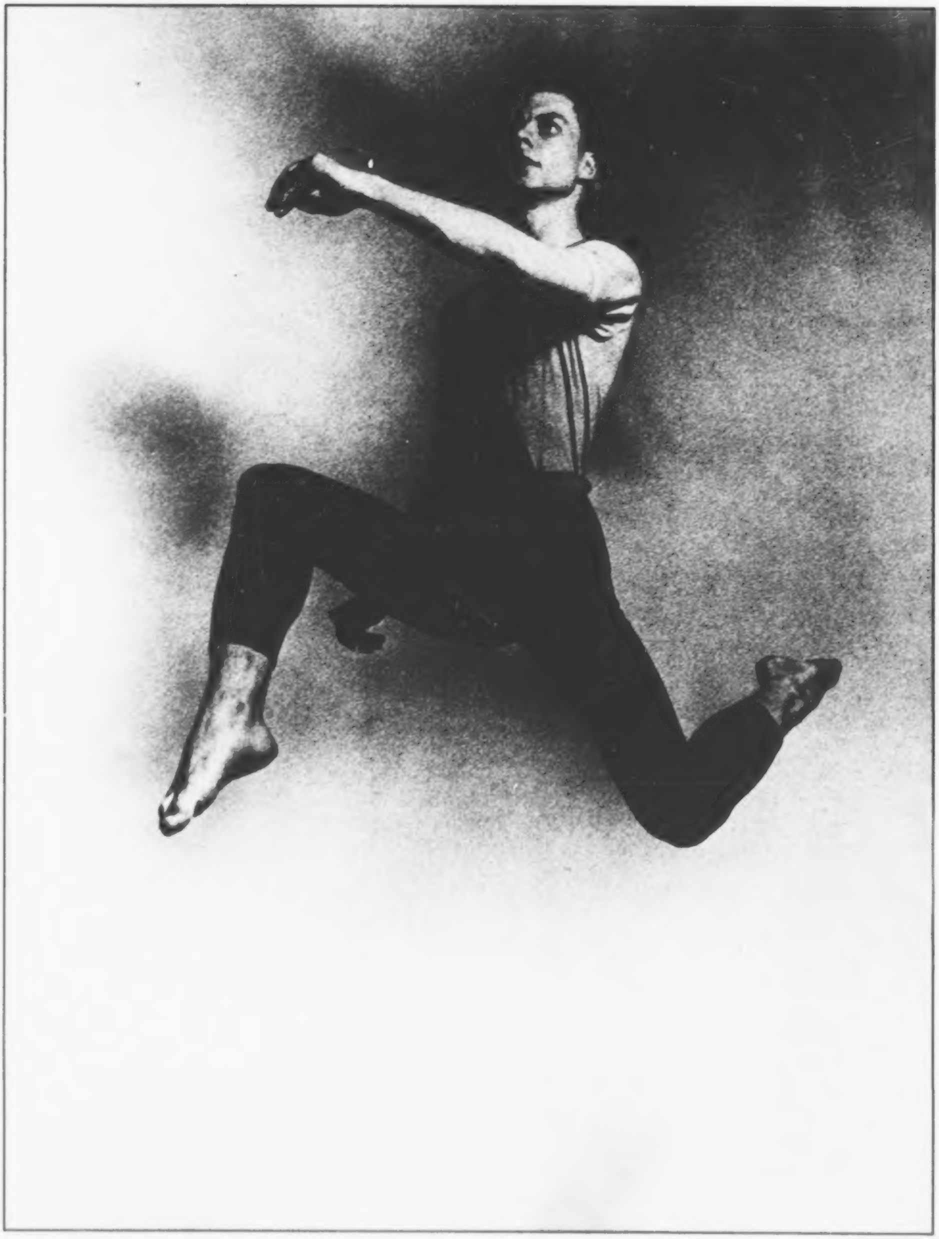
BLANCHE EVAN


1st Generation
B. Bernstein
J. Harris
Klein-Marrin
M. Leventhal
Levy
Loman
Merman
Naess
Rifkin-Gainer
2nd Generation
Cannon
F. Leventhal
Murphy
Estrin
Fersh
F. Leventhal McCall
Robinson
Singer

José Limón in performance, 1944. (Photo courtesy Barbara Morgan.)

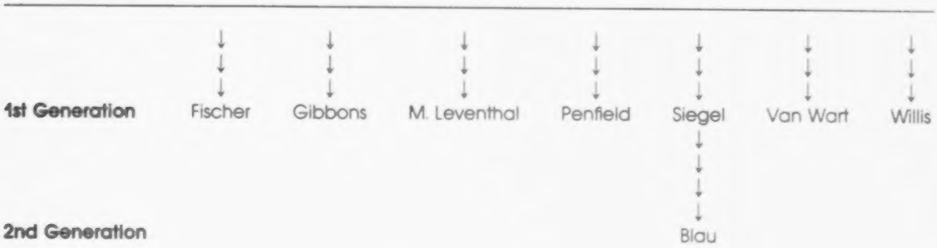
ALMA HAWKINS


1st Generation
Broide-Miller
Dosamantes-Alperson
Fletcher
M. Leventhal
Weisbrod
Valentine
2nd Generation
Estrin
Koshkin

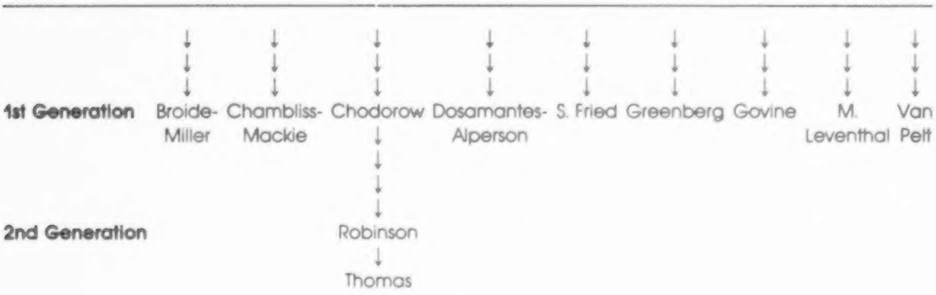


Merce Cunningham in performance, 1942. (Photo courtesy Barbara Morgan.)

LILJAN ESPENAK


1st Generation
Fischer
Gibbons
M. Leventhal
Penfield
Siegel
Van Wart
Willis
2nd Generation
Blau

TRUDI SCHOOP


1st Generation
Broide-Miller
Chambliss-Mackie
Chodorow
Dosamantes-Alperson
S. Fried
Greenberg
Govine
M. Leventhal
Van Pett
2nd Generation
Robinson
Thomas

Martha Graham in performance, 1940. (Photo courtesy Barbara Morgan.)

Concluding Remarks

Dance therapy began with a small group of pioneering individuals whose work was limited to the back wards of mental hospitals and to private dance studios. Built upon the foundations laid by these pioneers and shaped by a rich heritage of modern dance and psychoanalytic thought, today's dance therapy has achieved professional status within the mainstream of the mental health field. Nevertheless, dance therapists are still in a relatively young field, and as such, they remain open to new ideas and new approaches as they seek in their own unique ways to respond to the needs of those they treat.

Diversity is evident in the broad spectrum of theoretical and practical perspectives espoused in dance therapy today. Like all contemporary psychotherapists, dance therapists borrow, assimilate, and integrate theories from leaders in the psychotherapies, and adapt them in individual ways to dance therapy. Some dance therapists have borrowed more from preexisting theories and methodologies, others less. Some have relied more on various psychoanalytic concepts, while others have relied more on their knowledge of the movement process and/or on interactional techniques. There are many who integrate all of these. Some are in the process of developing new theoretical constructs.

Finally, in adapting any theoretical base to dance therapy, it is essential to see that base as only one view toward understanding the whole person. Even if that view is extremely broad and encompassing, no single view or concept can clarify all of the complexities of human dynamics and the treatment possibilities.

In short, theory is helpful in understanding many aspects of the patient but cannot replace the therapist's emotional openness to and awareness of the subtleties of human expression and communication. This in-depth sensitivity to the whole-individual, has been a cornerstone of dance therapy ideology, beginning with the major pioneers. This is *not* to imply that dance therapists should not use psychiatric nomenclature or draw from established theoretical constructs, but only that the overall benefits of theory and clinical jargon need always be kept in perspective and should never replace the kind of in-depth human knowledge which grows naturally out of the dance movement experience and out of the dance therapist's deep empathic attunement to the patient.

Just as there is a broad spectrum of theoretical frameworks within the field, so there is also a wide variety of intervention styles. At the extremes, some dance therapists rely heavily on directive techniques while others stress unhampered improvisation with little external influence. Still others emphasize the dance/movement interaction between patient and therapist. While dance therapists tend to support a particular style of intervention, it appears that these preferences are modified to meet the immediate needs of the patients.

Dance therapists draw from a wide range of possible intervention styles and theoretical bases in the same way that verbal psychotherapists use a variety of methods and theories. This broad spectrum of practical and theoretical approaches provides dance therapists with a communal pool from which they can draw when needed. It is this communal pool which unites dance therapists and the practice of dance therapy.

As we reflect upon the progress of dance therapy during the past 40 years, we see the development of a theoretical base as well as the rapid institutional and professional development of the field. With this growth and diversification, however, it is important that we not lose sight of the core elements that unite the profession. Today's dance therapists stand solidly on the shoulders of a small group of dance, dance therapy, and psychology pioneers who preceded them. This influence has been demonstrated throughout this text and was confirmed by the 1985 survey findings. By understanding the inherent similarities in our heritage, we are on stronger footing to explain who we are today and to promote the continued development of dance therapy as a cohesive and unified profession which encompasses a broad scope of practice.

At the same time, it is important to welcome differences. A cohesive and unified profesion, while requiring a recognition of commonality, does not necessarily require uniformity. It was, after all, the diversity of theory and practice among the original dance therapy pioneers that set the course for the current focus of the profession.

It is right that dance therapists stay this course, leaving doors open to as many variations and innovations as possible. In a sense, all dance therapists are pioneers, expressing their own unique synthesis of all that came before them every time they conduct a session. It is this creativity and respect for the individuality of the patient and the truthfulness of the moment that enables the field to grow and expand. Without it, dance therapy could not remain true to itself as a creative arts therapy and a healing art.

APPENDIX A

Survey Respondents

The following is a list of the survey respondents. All are ADTR's (Academy of Registered Dance Therapists), and all have demonstrated leadership in the field. The author's sincere thanks goes to:

Aiudi, Cher
Avstreih, Zoe Arlene
Basberg, Gunvor
Berger, Miriam Roskin
Berkowitz, Joan
Bernstein, Bonnie
Binder, Marcia Meizel
Blau, Bette
Bolender, Jeanette
Burton, Caroline
Canner, Norma
Cannon, Lou
Cassell, Abby
Chailklin, Sharon
Chambliss-Mackie, Louisa
Chodorow, Joan
Climenko, Johanna
Cowdery, Jean
Demos, Gina
Dipalma, Eleanor
Dosamantes-Alperson, Erma
Duggan, Diane
Dulicai, Dianne
Espenak, Liljan
Estrin, Barbara
Fersh, Isabel
Fischer, Judith
Fletcher, Diane
Fried, SuEllen
Ganet-Sigel, Janet
Gay, Remi
Gibbons, Mila
Govine, Barbara
Greenberg, Marilyn
Greenberg, Tamara
Hallen, Donna
Hamburg, Fran
Harris, Joanna
Harris, Rachel
Hawkins, Alma
Haynes, Juliann
Haze, Neala
Kalish-Weiss, Beth
Katz, Stephanie
Klein-Marrin, Berti
Klein, Virginia
Kleinman, Susan Rosenberg
Koch, Nana
Koshkin, Elisse
Kuettel, Tom
Lau, Julianna
Leventhal, Fern
Leventhal, Marcia
Levine, Felise
Levy, Fran
Lewis, Penny
Loman, Susan
Macarin-Mara, Lynn
Manning, Jane
Marsh, Irene
Mason, Kathleen
McCall, Debra
Merman, Hillary
Miller, Nitza Broide
Moffett, Jane
Murphy, Jim
Naess, Joan
Olin, Anne
Penfield, Kedzie
Polk, Elizabeth
Puder, Miriam
Reiss, Toni
Rifkin-Gainer, Iris
Robinson, Nina
Ruben, Gloria Simcha
Russell, Rhoda Winter
Samuelson, Emily
Sandel, Susan
Schmais, Claire
Schwinger, Karen
Serlin, Ilene
Siegel, Elaine

Silberman-Diehl, Linni
Singer, Susan Blumberg
Stanton, Judith Beers
Stark, Arlynne
Strauss, Amelie
Studenroth, Amy Wapner
Thomas, Deborah
Truppi-Hoff, Ann Marie
Valentine, Grace
Van Pelt, Pauline
Van Wart, Marjory
Vitiello, Erie
Wallock, Susan
Weiner, Shirley
Weisbrod, Jo Anne
White, Elissa Q.
White, Griselda
Willis, Charlotta
Zenoff, Nancy

APPENDIX B

American Dance Therapy Association

American Dance Therapy Association
73 Charter Members

Dian Averbuck
Irmgard Bartenieff
Beate Becker
Miriam R. Berger
Ruth Bernard
Ruthanna Boris
Nitza Broide-Miller
Mary Ann Buben
Judith Bunney
Marian Chace
Sharon Chaiklin
Pei-Fen Chin
Susan Constable
Martha Davis
Laura DeFreitas
Wynelle Delaney
Mildred Dickinson
Leslie Dinsmore
Francis Donelan
Liljan Espenak
Blanche Evan
Mary Fee
Joseph Fischer
Genieve Fox
Doris Fredericks
SuEllen Fried
Raoul Gelabert
Jane Ganet-Sigel
Sally Fitzpatrick Hanes
Alma Hawkins
Mildred Hill
Doris Hinton
Hawaii State Hospital
Beth Kalish-Weiss
Stephanie Katz
Annie Kemna
Susan Kleinman
Julianna Lau
Ruth Lauterstein
Mary Ann Lloyd
Sherry Martin
Diana B. McCarthy
Peggy Mitchell
Constance Moerman
Hilda Mullin
Joan P. Orr
Ruth Panofsky
Catherine Pasternak
Marjorie Pasternak
Forestine Paulay
Elizabeth Polk
Catherine Reisman
Irene W. Reiss
Dian Rosenfeld
Gloria Simcha Ruben
Susan Sandel
Maxine F. Schapiro
Lilian Schayer
Claire Schmais
Roberta Schlasko
Arlynne Stark
Dorothy Steigerwald
Alice Bovard-Taylor
Deborah Thomas
Barbara Weiner
Barbara Weintraub
Joyce Weir
Elissa Q. White
Griselda F. White
Mary Whitehouse
Minnie P. Wilson
Mary Jane Wolbers
Louise Yokum

American Dance Therapy Association
1966 Fact Sheet

NAME: AMERICAN DANCE THERAPY ASSOCIATION

PRINCIPAL OFFICE: 904 Walnut Avenue
Baltimore, Maryland 21229

PURPOSE: Establish and maintain standards of professional competence among dance therapists.

Promote education and training, thereby making dance therapy a fully accredited profession.

Establish effective communications among dance therapists, those in allied fields and the general public.

DEFINITION: Dance therapy is the planned use of any aspect of dance to aid in the physical and psychic integration of the individual.

BACKGROUND: Dance therapists are employed in 25 states, Canada, England, Sweden, Norway and Israel.

Areas of activity include: hospitals (psychiatric, occupational therapy, recreation), clinics, special schools, residential centers, halfway houses, reform schools and in some cases, private studios.

Malfunctions treated include: emotional disturbances, retardation, deafness, blindness, delinquency, perceptual disorders, cultural deprivation.

American Dance Therapy Association
Contacts for Regional and Local Acitvities

MEMBERS-AT-LARGE:

EAST
Cathy Crosky, ADTR
41 John Street
Williamstown, MA 01267

MIDWEST
Toni Reiss, ADTR
448 Peachtree Road
Lexington, KY 40509

WEST
Ama B. Phillips, ADTR
601 Brooklyn, #101
Oakland, CA 94606

CHAPTERS:

* FLORIDA
Martha Baker, DTR
406 25th Street, #5
Miami Beach, FL 33140

* MARYLAND/DC/VIRGINIA
Paul Sevett, DTR
549 11th Street, SE
Washington, DC 20003

* MIDWEST
Marylee Hardenbergh, ADTR
125 N. First Street
Minneapolis, MN 55401

MIDWEST CLUSTER GROUPS AND CONTACT PERSONS:

Illinois, Indiana, Michigan, Ohio:
Debra Benjamin Goldman, ADTR
1802 Elmwood Drive
Highland Park, IL 60035

Kansas, Nebraska, Missouri, Iowa:
William Charles Freeman, ADTR
P.O. Box 8051
Kansas City, KS 66208

Minnesota:
Kathleen Devereaux
1081 Fairmount Ave.
St. Paul, MN 55105

Wisconsin:
Rena Kornblum, ADTR
1304 Jenifer Street
Madison, WI 53703

Colorado:
Jan Isaacs Henry, ADTR
14 East Jefferson
Colorado Springs, CO 80907

* NEW ENGLAND/CANADA
Vivien Marcow, ADTR
103 Abbottsford
Brookline, MA 02146

* NEW JERSEY
New Jersey Chapter
c/o Geri Silk
PO Box 604
Madison, NJ 07940

* NEW YORK
Anna Mitcheltree, ADTR
237 East 5th Street, #14
New York, NY 10003

* NORTHERN CALIFORNIA
Carol Bruno, ADTR
947 El Centro Avenue
Napa, CA 94558

* PHILADELPHIA
Diane M. Bowers-Shelly, DTR
4336 Boone Street
Philadelphia, PA 19128

* SOUTHERN CALIFORNIA
Marsha Weltman, ADTR
11611 Chenault, #205
Los Angeles, CA 90049

* TEXAS
Kat Emmons
11845 West Ave. #511
San Antonio, TX 78216

STUDY GROUPS

Minnesota Study Group
Marylee Hardenbergh, ADTR
125 North First Street
Minneapolis, MN 55401

South Central Study Group
Kat Emmons
11845 West Ave. #511
San Antonio, TX 78216

* Official Chapters of ADTA. Only members of National A.D.T.A. may be members of a Chapter. Chapter Membership Fees: Students: $5.00. Professional Associate and Contributing members $10.00.

American Dance Therapy Association
Credentials Committee

Oct. '70–'71	Elected Member: *Chair*, Elissa White Elected Member: Irmgard Bartenieff Elected Member: Susan Sandel
October 1972	Elected Member: *Chair*, Elissa White (2 year term) Elected Member: Irmgard Bartenieff (3 year term) Elected Member: Ann Lohn (2 year term) Elected Member: Barbara Govine (1 year term) Board-Appointed Member: Miriam Berger (3 year term) Non-Voting Standards & Ethics Ex-Officio Member: Wynelle Delaney
October 1973	Elected: *Chair*, Ann Lohn Elected: Elissa White Elected: Irmgard Bartenieff Elected: Barbara Govine (3 year term) Appointed: Miriam Berger S & E: Wynelle Delaney
October 1974	Elected: *Chair*, Ann Lohn (3 year term) Elected: Arlynne Samuels (3 year term) Elected: Irmgard Bartenieff Elected: Barbara Govine Appointed: Susan Kleinman (1 year app't) S & E: Wynelle Delaney
October 1975	Elected: *Chair*, Barbara Govine Elected: Arlynne Samuels Elected: Sharon Chaiklin (3 year term) Elected: Ann Lohn Appointed: Susan Kleinman (3 year term) S & E: Wynelle Delaney/Hilda Mullin
October 1976	Elected: *Chair*, Arlynne Samuels Elected: Beth Kalish (2 year term) Elected: Ann Lohn Elected: Miriam Berger (3 year term) Appointed: Susan Kleinman S & E: Susan Lovell
October 1977	Appointed: *Chair*, Susan Kleinman Elected: Alice Taylor (3 year term) Elected: Beth Kalish Elected: Caroline Burton (3 year term) Elected: Miriam Berger S & E: Susan Lovell
October 1978	Elected: *Chair*, Carrie Burton Elected: Alice Taylor Elected: Lin Chapot Vernon (3 year term) Elected: Miriam Berger Appointed: Kathlyn Spencer (3 year term) S & E: Susan Lovell

October 1979	Elected: *Chair*, Carrie Burton Elected: Alice Taylor/Miriam Berger Elected: Lin Vernon Elected: Frances Hamburg (3 year term) Appointed: Kathlyn Spencer S & E: Susan Lovell
October 1980	Appointed: *Chair*, Kathlyn Spencer Elected: Joanna Harris (3 year term) Elected: Lin Vernon Elected: Nana Sue Koch (3 year term) Elected: Frances Hamburg S & E: Joan Naess
October 1981	Elected: *Chair*, Frances Hamburg Elected: Joanna Harris Elected: Betty Louisa Chambliss (3 year term) Elected: Nana Sue Koch Appointed: Shana Swiss S & E: Joan Naess
October 1982	Elected: *Chair*, Nana Sue Koch Elected: Joanna Harris Elected: Betty Louisa Chambliss Elected: Jeri Gunod Mendelsohn Appointed: Shana Swiss
October 1983	Elected: *Chair*, Nana Sue Koch Elected: Betty Louisa Chambliss Elected: Jeri Gunod Mendelsohn Appointed: Stephanie Endler
October 1984	RESTRUCTURED TO ACCOMODATE 2-LEVEL REGISTRY Elected: *Overall Chair*, Nana Sue Koch Elected: *Chair, ADTR Subcommittee*, Betty Louisa Chambliss Appointed: Stephanie Endler Elected: Lou Cannon (1984–1986) Appointed: *Chair, DTR Subcommittee*, Barbara Estrin Appointed: Sally Kondziolka (1984–1986) Elected: Jane Ganet-Sigel (1984–1986)
October 1985	Elected: *Overall Chair*, Nana Sue Koch Elected: *Chair, ADTR Subcommittee*, Lou Cannon Appointed: Stephanie Endler (1985–1987) Elected: Shira Musicant (1985–1987) Appointed: *Chair, DTR Subcommittee*, Sally Kondziolka Appointed: Barbara Estrin Elected: Jane Ganet-Sigel
October 1986	Appointed: *Overall Chair*, Sally Kondziolka (1986–1987) Elected: *Chair, ADTR Subcommittee*, Lou Cannon Appointed: Stephanie Endler Elected: Shira Musicant Appointed: *Chair, DTR Subcommittee*, Barbara Estrin Elected: Jane Ganet-Sigel Appointed: Cathy Crosky (1986–1988)

American Dance Therapy Association
Committee on Approval

After restructure in January 1979

January 1979

Chairperson:	Sharon Chaiklin	Supervisor
	Alma Hawkins	Faculty
	Claire Schmais	Faculty
	Mara Capy	Faculty
	Lee Gural	Public (Psych.)
	Diane Dulicai	Alternate—Faculty
	Johanna Climenko	Alternate—Supervisor

January 1980

Chairperson:	Sharon Chaiklin	(until July 1980) Supervisor
	Claire Schmais	(from July 1980) Faculty
	Alma Hawkins	
	Mara Capy	(until July 1980)
	Lee Gural	
	Dianne Dulicai	(alternate until July 1980 when took Mara Capy's term)
	Johanna Climenko	(alternate—replaced by SuEllen Fried and made representative—supervisor)
	SuEllen Fried	(replacing S. Chaiklin) Alternate—Supervisor

Extended to May 1981

Chairperson:	Claire Schmais	
	Alma Hawkins	Faculty
	Dianne Dulicai	Faculty
	Johanna Climenko	Supervisor
	Lee Gural	Public
	Beth Kalish-Weiss	(alternate—Faculty)
	SuEllen Fried	(alternate—Supervisor)

October 1981 to May 1982

Chairperson:	Claire Schmais	Faculty	
	Alma Hawkins	Faculty	1979–81
	Dianne Dulicai (reappointed)	Faculty	1981–83
	Johanna Climenko	Supervisor	1979–81
	Alfred Stamm	Public (Social Work)	1981–84
	Beth Kalish-Weiss	Faculty	1980–83
	Susan Kleinman	Supervisor	1981–84

Committee on Approval
(Continued)

October 1982 to May 1983

Chairperson:	Beth Kalish	Faculty
	Marcia Leventhal	Faculty
	Mara Capy	Faculty
	Remi Gay	Supervisor (replace S. Kleinman)
	Sharon Chaiklin	Faculty (interim for D. Dulicai)
	Fred Stam	Public

May 1984

Chairperson:	Sharon Chaiklin	Faculty
	Marcia Leventhal	Faculty
	Mara Capy	Faculty
	Remi Gay	Supervisor
	Erma Alperson	Faculty
	Fred Stam	Public

October 1984

		Terms of office end
Chairperson:	Sharon Chaiklin	May 31, 1986
	Marcia Leventhal	1985
	Mara Capy	1985
	Fran Hamburg	1985
	Erma Alperson	1986
	Fred Stam	1987

April 1986

Chairperson:	Sharon Chaiklin	May 31, 1989
	Fred Stamm	1987
	Erma Alperson	1989
	Fran Hamburg	1987
	Phyllis K. Jeswald	1988
	Nana Sue Koch	1988

American Dance Therapy Association
National Annual Conferences

1st	1966	New York City Library of Performing Arts	Claire Schmais
2nd	1967	Washington, D.C. Ambassador Hotel	Dorothy Vislocky Steingerwald
3rd	1968	Madison, Wisconsin Madison Inn	Sharon Chaiklin Susan Rosenberg
4th	1969	Philadelphia, Pennsylvania Warwick Hotel	Beth Kalish-Weiss
5th	1970	New York City Hotel Lexington	Claire Schmais
6th	1971	Washington, D.C. Hotel Marriott	Diana Cook
7th	1972	Santa Monica Hotel Mirimar	Barbara Govine
8th	1973	Overland Park, Kansas Glenwood Manor	SuEllen Fried
9th	1974	New York City Roosevelt Hotel	Miriam Berger Dianne Dulicai Linni Silberman-Diehl
10th	1975	Pacific Grove, California Asilomar	Joanna Harris Barbara Govine
11th	1976	Washington, D.C. L'Enfant Plaza	Gunvor Basberg
12th	1977	Toronto, Canada Sheraton Centre	Julianna Lau
13th	1978	Seattle, Washington Red Lion Inn	Ruthanna Boris Stephanie Katz
14th	1979	Philadelphia, Pennsylvania Philadelphia Marriott	Diana Felber
15th	1980	Los Angeles, California New Otani Hotel	Erma Alperson
16th	1981	Madison, Wisconsin University of Wisconsin	Deborah Thomas
17th	1982	Rye, New York Rye Town Hilton	Remi Gay
18th	1983	Pacific Grove, California Asilimar	Sherry Gould
19th	1984	Boston, Massachusetts	Carol Kahn President Nancy Pieser Krieger
20th	1985	NACATA New York, NY	NACATA
21st	1986	Chicago, Illinois	Debra Goldman Pam Brownstein

American Dance Therapy Association Board of Directors: Members at Large

1966–1968	1968–1969	1969–1971	1971–1973	1973–1975	1975–1977	1977–1979	Board Restructured	1979–1981	1981–1983	1983–1985
Irmgard Bartenieff	Ruthanna Boris	Jane Adler Massachusetts	Laura DeFreitas New York	Virginia Dryansky New York	Gunvor Basberg Washington, DC	Rebecca Bennett Washington, DC	East Coast	Fern Leventhal New York	Fern Leventhal New York	Cathy Crosky
Ruthanna Boris	Jane Ganet Illinois	Jane Ganet Illinois	SuEllen Fried Kansas	Rebecca Leeds Israel	Penny Bernstein New Hampshire	Jennifer Hill Connecticut	Midwest	Stephanie Katz Michigan	K. Spencer, CO resigned 10/81 Jan I. Henry	Toni Reiss
Pei Fen Chin	Alma Hawkins	Susan Rosenberg Illinois	Barbara Govine California	Felise Levine New York	SuEllen Fried Kansas	Stephanie Katz Michigan	West Coast	Felise Levin California	Felise Levin California	Ama Phillips
Joseph Baker	Rhoda Winter Russell Pennsylvania	Rhoda Winter Russell Pennsylvania	Susan Rosenberg Illinois	Kathleen Mason California	Deborah Thomas Wisconsin	Marcia Leventhal New York				
Alma Hawkins	Trudi Schoop	Clair Schmais New York	Susan Sandel Connecticut	Lucille Ormay New York	Shirley Weiner New Jersey	Deborah Thomas Wisconsin				
	Harold Streitfeld	Susan Susskind Connecticut	Maja Schade Pennsylvania	Robert Shlasko Gottlieb New York						
	Elissa G. White New York	Louise Yokum California	Claire Schmais New York	Shirley Weiner New Jersey						
		Elissa G. White New York	Wynelle Delaney Texas	Jo Weisbrod Maryland						

American Dance Therapy Association Board of Directors

Conferences	1966: N.Y.C. 1967: Wash. DC	1968: Wisc. 1969: Phila.	1970: N.Y.C. 1971: Wash. DC	1972: Calif. 1973: Kan. City	1974: N.Y.C. 1975: Asilomar	1976: Wash. DC 1977: Toronto		1978: Seattle 1979: Phila.	1980: LA, CA 1981: Madison	1982: New York 1983: SF, CA	1984: Boston 1985: New York
Position	1966–1968	1968–1969	1969–1972	1972–1974	1974–1976	1976–1978	Restructured	1978–1980	1980–1982	1982–1984	1984–1986
President	Marian Chace	Sharon Chaiklin	Sharon Chaiklin	Beth Kalish-Weiss	Joan Chodorow	Judith Bunney	President	Judith Bunney	Erma D. Alperson	Arlynne Stark	Arlynne Stark
Vice President	Sharon Chaiklin	Beth Kalish	Beth Kalish	Joan Chodorow	Miriam Berger	Erma D. Alperson	Vice President	Erma D. Alperson	Arlynne Stark	Stephanie Katz	Stephanie Katz
Corresponding Secretary	Catherine Pasternak	Stephanie Katz	Diana Cook	Linni Silberman-Diehl	Erma Alperson	Ivy Lee Cole	Secretary	Joan Lavender	R. Bennett resigned 3/81 S. Katz	Susan Kleinman	Susan Kleinman
Recording Secretary	Elissa White	Ann Lohn	Roselee Perkarsky	Dianne Dulicai	Diane Fletcher	Joan Lavender	Treasurer	Elissa White	Elissa White	Judith Fried	Judith Fried
Treasurer	Arlynne Stark	Arlynne Stark	Ann Lohn	Judith Bunney	Judith Bunney	C. Miller/A. Stark	Communications	Diane Duggan	Elise Billock	Michael Britton	Michele Gargan
By-Laws	Miriam Berger	Connie Moerman	Arlynne Stark	Jane Kettering	Diane Dulicai	Diane Dulicai	Education	Linni Silberman-Diehl	Florette Orleans	Judith Fischer	Jody Wager
Publicity	Beth Kalish-Weiss	Miriam Berger	Miriam Berger	Gloria Ruben	Lee Strauss	Diane Duggan	Government Affairs	Marilyn Greenberg	Marilyn Greenberg	Helen McKibben	Helen McKibben
Standards and Ethics	Millie Hill	Joseph Fischer	Elissa White	Wynelle Delaney	W. Delaney H. Mullin	Susan Lovell	Standards and Ethics	Susan Lovell	Joan Naess	Joan Naess	Remi Gay
Education	Claire Schmais	Dorothy Steiger	Liljan Espenak	S. Brainard/J. Harris	Joanna Harris	Judith Beers	Newsletter (Appointed by Board)	Florette Orleans	Judith Fried	Cheryl Planert-Geffen	Cheryl Planert-Geffen
Newsletter	Deborah Thomas	Irmgard Bartenieff	Penny Lewis	Penny Lewis	Linni Silberman-Diehl	Linni Silberman-Diehl					

American Journal of Dance Therapy

VOL. I, 1 & 2 VOL. II, 1 & 2		VOL. III, 1 & 2 VOL. 4, 1 & 2	VOL. 5 VOL. 6	VOL. 7
1976–1978	Restructured	1978–1980	1982–1983	1984–
Joanna Harris Editor-in-Chief	Editor-in-Chief	Rachel Harris	Claire Schmais	Jeri Gunod Mendelsohn
Erma Alperson Interdisciplinary Issue Editor	Associate Editor	Susan Kleinman	Elissa Q. White	Amy Studenroth
Marcia Leventhal, Proceedings Issue Editor	Book Review Editor	Lisa Hillyer (resigned)		
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Lisa Friedlander, Book Reviews & Events Editor		Seymour Fisher, Ph.D.	Jeri Gunod Mendelsohn	Kyle Buckley
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		Beth Kalish-Weiss, Ph.D., DTR	Enid Wolfe, Ph.D. Jesse Geller Dr. Stanley Brodsky George Getzel, Ph.D.	Grace Valentine Clarence Shulz Steven Thayer

APPENDIX C

Dance Therapy Questionnaire

Questionnaire for Academy of Registered Dance Therapists Registered on or before 1980

I. GENERAL INFORMATION

Please answer YES or NO to the following questions by *circling* your answer and filling in the blanks:

A. Published 3 or more Dance Therapy articles: YES or NO
If YES, please give approximate number: ________

B. Taught Dance Therapy in a degree program for 4 or more years: YES or NO
If YES, give number of years: ________.

C. Taught or trained Dance Therapists privately for 4 or more years: YES or NO
If YES, give number of years: ________.

D. Published a book or books on Dance Therapy: YES or NO

E. Board member and/or chairperson on a Board elected committee for 3 or more terms: YES or NO—If Yes, give number of terms: ________.

F. Conducted 10 or more special Dance Therapy presentations at any of the following: professional conferences; grand rounds; panel participation; guest speaker at colleges; mental health clinics; schools; etc. (This question does not include teaching Dance Therapy on an ongoing basis. It does include special workshops.): YES or NO

G. Supervised Dance Therapists for 5 or more years: YES or NO
(indicate number of years) ________ Graduate Student Internships
________ Private Supervision
________ Other Student Internships

H. Education:	*College/Univ.*	*Coordinator*	*State*	*Dates*
Bachelors Deg.	________	________	____	____
Masters Deg.	________	________	____	____
Doctorate	________	________	____	____
Other	________	________	____	____

II. ACADEMIC AND NON-ACADEMIC DANCE THERAPY TRAINING

Name Of Dance Therapist(s) Who Trained You	Give Dates And Circle "A" If Part Of Academic Training & "N" If Part Of Non-Academic Training	Check Appropriate Columns To Indicate Degree Of Influence Either Major Or Minor		If This Training Was Helpful Primarily With One Patient Population Please Indicate What Population	Which Leader(s) In The Field Influenced Your Trainer?	Where? Give Name of Institution & Location	Who Supervised You?	With What Patient Population	How Long?
		Major	*Minor*						
______	A or N ______	____	____	______	______	Inst. ____ Loca. ____	______	______	______
______	A or N ______	____	____	______	______	Inst. ____ Loca. ____	______	______	______
______	A or N ______	____	____	______	______	Inst. ____ Loca. ____	______	______	______
______	A or N ______	____	____	______	______	Inst. ____ Loca. ____	______	______	______
______	A or N ______	____	____	______	______	Inst. ____ Loca. ____	______	______	______

III. OTHER TRAINING AND INFLUENCES

A. What *areas* of *psychological theory* have been most helpful to you in your work as a Dance Therapist, and with what patient population(s)?

		Psychological Frame of Reference	*Patient Population*	*Date of Training*	*Who Trained You?*
MAJOR INFLUENCE	1				
	2				
	3				
MINOR INFLUENCE	1				
	2				
	3				

B. 1. Who and what technique in the area of *dance* has most influenced your work as a Dance Therapist? Please specify.

	Teacher	*Style*	*Dates*
1			
2			
3			
4			

2. The following refers to your experience, if any, in dance performance, choreography, and/or teaching dance, and the influence this experience has had on your work as a Dance Therapist. If you've had no experience in any of these areas, simply check the column NA (not applicable).

			Influence	
NA	*Area of Experience*	*Length of Time*	*Major*	*Minor*
	Dance Performance			
	Choreography			
	Teaching Dance			

If you indicated "major influence" for any of these, please explain:

3. Number of years you received Dance Training ________.

C. Movement Analysis Background:

1. Have you received training in Laban Movement Analysis (also known as Effort/Shape)? YES or NO—If yes, gives dates ________.
2. Are you a Certified Movement Analyst? YES or NO

D. Are there any *other* past or present influences in your work? If so, please enumerate:

____

____

____

E. Below is a list of the major categories of influence. Please enumerate them in order of their importance to your overall work as a Dance Therapist, with #1 for most important, #2 for the next important, etc. Use #0 for no influence at all. (You may use a number twice to indicate equal importance.) There are 2 columns, column #1 indicates the earlier part of your career and column #2 your current attitudes. To answer column #1, pretend you are in an earlier stage of your career and prioritize accordingly. Then proceed to Column #2.

Degree of Influence		
Column #1 (past)	*Column #2* (present)	
________	________	Dance
________	________	Laban Movement Analysis
________	________	Dance Therapy Training
________	________	Psychological Theory
________	________	Private Supervision
________	________	Your Experience as a Client in Dance Therapy
________	________	Your Experience as a Client in Verbal Therapy
________	________	Other (specify) ________________
________	________	Other (specify) ________________

IV. DANCE THERAPY PRACTICE

A. How many years have you practiced Dance Therapy professionally? ________ years.

B. How many years have you been a Registered Dance Therapist? ________ years.

C. Where have you worked? Please enumerate on chart below:

	Where (Name And Location Of Place Of Work)	Patient Population	Dates	# Of Years
Early Profession Practice	________________	________	____	____
	________________	________	____	____
	________________	________	____	____
Present Practice	________________	________	____	____
	________________	________	____	____
	________________	________	____	____

D. 1. Have there been any noteworthy shifts in the theoretical and/or practical aspects of your work over the years. YES or NO. If YES, please elaborate:

____

____

2. Do you believe that your shift is representative of a broader or future trend in the field of Dance Therapy? YES or NO. If YES, please elaborate:

____

____

V. CONTRIBUTIONS TO THE FIELD

A. *Teaching*: If you have taught courses/workshops in Dance Therapy, please fill in the following. If your teaching is too extensive to fill in each course, just summarize into categories.

1. *Academic*

	What Taught— Title &/Or Subject Matter	What *Type* of Program—Include Name Of Institution	What *Type* Of Students (e.g. Nurses, D.T.s O.T.s, etc.)	Dates & How Long	Of Your Mentors, Whose Work did &/Or Do You Espouse While Teaching?
1					
2					
3					
4					

2. *Non-Academic*

	What Taught Title &/or Subject Matter	What *Type* of Program—Give Name of Organization Sponsoring You If Any	What *Type* of Students (e.g. Nurses, D.T.s O.T.s, Etc.)	Dates & How Long	Of Your Mentors, Whose Work Did &/Or Do You Espouse While Teaching?
1					
2					
3					
4					

3. *Supervisory Positions in Dance Therapy*

	Where—Give Name Of Institution If Any	*What Type* of Students (e.g. Nurses, D.T.s, O.T.s, etc.)	What Patient Population	Dates & How Long	Of Your Mentors Whose Work Did &/Or Do You Espouse	Approx. How Many Students Did You Supervise?
1						
2						
3						
4						

4. What percentage of your students continued practicing Dance Therapy? ____ %

5. What percentage took your teaching into other fields? ________ %
What fields?

____

____

B. *Publications*: Please list titles and dates of articles, books, videos/films etc.

____

____

C. *Workshop/Lectures*: Please list presentations and lectures. (If there are too many to list separately just give a summation.)

	Where	*To Whom*	*Date*	*Subject*
1				
2				
3				
4				

D. *Professional Organizational Activities*—Please list and date any organizational contributions you have made to the field. If you have been on the Board of the ADTA just indicate by saying *Board Membership*. This information is available to us.

____

____

____

E. *Other Contributions*—Are there any other contributions you have made to the field?

____

____

____

We would appreciate your signing the following statement:

I, ______________________________, understand that in filling out this questionnaire, I am giving Fran Levy permission to use my questionnaire responses in her forthcoming book. I also understand that I will be given proper credit for any and all direct and/or indirect quotes which Fran abstracts from my questionnaire responses.

Signed ______________________________________ Date ____________

(your signature)

Thank you again for taking the time to fill out the questionnaire!

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Fran J. Levy, Ed.D., M.S.W., A.D.T.R.
Academy of Registered Dance Therapists
Diplomate in Clinical Social Work
Doctorate in Creative Arts Therapies
Fellow in the Association for Psychotherapy and Psychodrama

Dr. Levy has a private practice in New York and conducts training seminars for dance therapists. In her work, she incorporates her experiences as an artist, dancer, and psychodramatist with her work as a psychotherapist. Her eclectic and creative approach to dance therapy is described in this book along with an in-depth exploration and organization of the entire field. Dr. Levy's deep understanding of human needs and the impact of body movements and self expression on growth and development are reflected in this work. Dr. Levy has been teaching and lecturing at colleges, universities, and in mental health settings since 1972. Her innovative work is known and respected worldwide.

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Psychologist and Author of several books—Director of the Career Center at the University of Texas, Austin

National Dance Association
American Alliance for Health, Physical Education, Recreation, and Dance
1900 Association Drive
Reston, Virginia 22091

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